

READY TO RESPOND

MENTAL HEALTH
BEYOND CRISIS
AND COVID-19



NASMHPD

Reimagining a Sustainable and
Robust Continuum of Psychiatric Care

September 2021

Foreword

The Substance Abuse and Mental Health Services Administration (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 these conditions. SAMHSA partners with stakeholders at all levels to further its mission. The National Association of State Mental Health Program Directors (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. Together, SAMHSA and NASMHPD have been working diligently to stay abreast of and be responsive to the needs of local communities and state leaders.

With the ongoing COVID-19 pandemic, the pre-pandemic rising suicide rates, the opioid crisis and numerous challenges in meeting demands for mental health services across the country, the 2021 Compendium of *Ready to Respond: Mental Health Beyond Crisis and COVID-19*, comes at a critical time. Commissioned by SAMHSA and executed by NASMHPD, the *Ready to Respond* compendium provides 10 authoritative papers on critical topics of our time related to crisis services and post-COVID-19 vision for mental health services.

Mental health system leaders on a local, state, and national level need ongoing resources to help providers deliver needed services and supports, help set policy agendas, inform legislators about best practices to advocate for funding, and promote tools to help establish needed programs to continue to build out a robust mental health continuum of care. This compendium offers just such a resource, and we are delighted to offer it as a coordinated set of guiding documents richly written and full of helpful information from the nation's leading experts in areas ranging from children in crisis to financing and data collection, partnership with law enforcement in crisis response, suicide prevention and disaster behavioral health response. Throughout the series the authors contemplate issues of diversity and equity to help continue to drive services in the direction of equal access to all. As the single federal authority focused on the impacts of mental illness and substance use disorders, it is critical that our nation is indeed ready to respond. We are grateful to the numerous contributors who have helped shape such an important overview.

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Acknowledgements

We are grateful for the work done to put these papers together, both in their original conceptualization in partnership between the Substance Abuse and Mental Health Services Administration and the National Association of State Mental Health Program Directors, and in their writing by the individual authors. We also wish to express our gratitude to both Debra A. Pinals, M.D. for her leadership and subject matter expertise and to Elizabeth Sinclair Hancq, MPH for her skillful research and technical assistance as both helped edit, design and compile this series of papers to make it what it is. Also, thanks to Malkah Pinals for her graphic design skills for a cover that portrays the images of a continuum of care linked together across an array of crisis supports and services, all drafted and executed in between shifts doing direct care for persons with serious mental illness. Thank you to the lead authors and co-authors of the papers: Debra Pinals, M.D.; Arlene Hahn Stephenson, M.A.S.; Madelyn S. Gould, Ph.D., M.P.H.; Alison Lake, M.A.; Matthew L. Edwards, M.D.; Kristin A. Neylon, M.A.; Kenneth M. Rogers, M.D.; Louise Johnson, M.S.W.; Jayla O’Neal, M.D.; David de Voursney, M.P.P.; Francine Arienti, M.A.; Kevin Martone, L.S.W.; Kirsten K. Beronio, J.D.; Stephen Phillippi, Ph.D.; Brian Bumbarger, Ph.D.; and Robert Shaw, M.A. Thank you to the NASMHPD team for their collaborative efforts in developing this year’s series, including David Miller, Project Director, for overseeing this important effort and Aaron Walker for his excellent work and dedication in coordinating the development of these key resources. This series is an outstanding set of resources that will help in improving services for people in crisis with mental health and substance use issues across the life span and in unique geographical areas. We especially thank the public health and behavioral health leaders across the country that helped inform this series and help people in crisis every day.

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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.

This work was developed under Task 2.2 of NASMHPD’s Technical Assistance Coalition contract/task order, HHSS283201200021/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

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READY TO RESPOND

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AND COVID-19



NASMHPD

Reimagining a Sustainable and
Robust Continuum of Psychiatric Care

September 2021

Ready to Respond: Mental Health Beyond Crisis and COVID-19



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***First in the 2021 Ready to Respond Series of Ten Technical Assistance Briefs
focused on Beyond Beds, Reimagining a Sustainable and Robust Continuum of
Psychiatric Care***



National Association of State Mental Health Program Directors

www.nasmhpd.org/content/tac-assessment-papers

September 2021

Acknowledgements:

Working on these papers is an honor and a privilege, and they could not be done as well without the able and steady assistance of Elizabeth Sinclair Hancq, MPH, who demonstrated her calm editorial and research skills as the Technical Research Assistant for this paper, and assisted in the editing and formatting, design and formatting process of the entire compendium of 2021 technical assistance papers. Special thanks as always go to the NASMHPD team, with gratitude to Brian Hepburn, M.D., NASMHPD Executive Director, for giving me this opportunity to focus on this series and contribute to the national dialogue, as well as to Aaron Walker, Meighan Haupt, and Greg Schmidt, for their patience and diligence behind the scenes. Thanks to Ms. Doris Fuller who helped create the *Beyond Beds* construct and more. Thanks go to Malkah Pinals this year for her graphic art skills and patience, with input and comments from the SGERP team. Also, acknowledgements go to colleagues from the Behavioral Health and Developmental Disabilities Administration at the Michigan Department of Health and Human Services for continually striving to improve behavioral health services in that state. This year as always I wish to acknowledge collaborators from around the country in systems in mental health, developmental disabilities, and substance use services, along with other key partners including those who come from legislatures, courts, correctional systems, child welfare and juvenile justice that have helped inform not only the content of this paper but who have helped us navigate COVID-19 and make a difference to people with complex needs every day.

Disclaimer:

The views, opinions, content and positions expressed in this paper are those of the author and do not necessarily represent or reflect the official views, opinions, or policies of any governmental, academic, or other institution with whom the author is affiliated; nor does mention of trade names, commercial practices, or organizations imply endorsement by the U.S. government, any state government, academic or other institution.

Recommended Citation:

Pinals, D. A. (2021). *Ready to Respond: Mental Health Beyond Crisis and COVID-19*. Technical Assistance Collaborative Paper No. 1. Alexandria, VA: National Association of State Mental Health Program Directors.

This work was developed under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS283201200021/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

Abstract:

The current landscape of mental health services reflects both tremendous challenges and opportunities. With the impact of COVID-19 front and center in the national discourse, and the planning for a system involving a 988-crisis response, there is much work ahead. This paper, *Ready to Respond*, is the umbrella paper for the 2021 technical assistance coalition series developed through the National Association of State Mental Health Program Directors in partnership with the Substance Abuse and Mental Health Services Administration. It aims to lay out a roadmap as states emerge from the pandemic and need, more than ever, a full continuum of psychiatric care. As an outgrowth of a policy framework looking “beyond beds” within inpatient state hospitals as a single solution to improving mental health outcomes, the current discourse centers around access to crisis services. Yet, in order to best respond to demand, an entire array of services is needed both to prevent crises in the first place and to provide longer term supports beyond a crisis period for diverse populations of all ages with mental illness and substance use disorders, as well as those with co-occurring complex conditions. These services will require coordinated funding and planning with a broad group of stakeholders to address among other things equity and reducing the likelihood of suicide, overdose, criminal legal entanglements, homelessness, unemployment, or other untoward outcomes. The paper reviews recent behavioral health system demands and highlights seven key priority areas for consideration to build a sustainable, robust and more complete psychiatric care continuum.

Highlights:

- There have been significant catalysts that have culminated in the focus on building out a more robust crisis continuum of care.
- The emotional toll of COVID-19 is an area that requires the attention of state mental health leaders
- Health equity may help shape future reductions in disparities in mental health outcomes
- Workforce challenges are highlighted as a major potential barrier to developing a more robust system of services, though the use of telepractices may help expand work opportunities and access to care.

Recommendations for the Post-COVID-19 Future:

1. Expand and achieve a full continuum of crisis services.
2. Rebuild and reboot a robust, diverse, and well-qualified workforce.
3. Expand telehealth practices while ensuring ongoing quality and access.
4. Foster integration of disaster behavioral health into emergency preparedness and response.
5. Consider creative financial opportunities to maximize access to crisis response and other community-based mental health and substance use services with no wrong door.
6. Focus intentionally on diversity, equity and inclusion to reduce disparities in mental health outcomes.
7. Enhance interconnectedness with other systems and across borders for improved global responses

The National Association of State Mental Health Program Directors (NASMHPD), on behalf of the Substance Abuse and Mental Health Services Administration (SAMHSA), issued in 2017 a series of technical assistance papers on the need to shift the focus from building more state hospital beds to building a full and complete psychiatric continuum of care. The first paper in that series, *Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care*, laid a foundation from which national and international dialogue ensued.¹ The notion that psychiatric hospitalization is a key part of psychiatric care for those who need it has not shifted. However, there is increasing recognition that persons with serious mental illness, many of whom also have substance use disorders, need more than just psychiatric hospital beds. Just like in medical care, a complete continuum of services is necessary to meet the demands of persons with mental illness who may have any number of co-occurring complex conditions. In the four years surrounding the time of release of *Beyond Beds*, efforts around the country grew to examine and expand the behavioral health continuum, looking at models and goals both from the national and international literature. Each year, new NASMHPD technical assistance papers followed the theme of *Beyond Beds*, with approximately 10 papers and an overarching umbrella paper to establish a road map (Figure 1).^{2,3,4,5}

Figure 1: NASMHPD Technical Assistance Coalition Series Umbrella Papers 2017-2020

2017 *Beyond Beds: The Vital Role of a Full Continuum of Psychiatric Care*: set forth policy priorities of establishing a robust psychiatric continuum of care and looking beyond inpatient services as a single solution to the challenges for persons seeking services for mental illness.

2018 *Bolder Goals, Better Results: Seven Breakthrough Strategies to Improve Mental Illness Outcomes*: delineated seven bold goals, from ending homelessness and suicide to getting immediate access to care, as a way to build a roadmap to better mental illness outcomes.

2019 *Beyond the Borders: Lessons from the International Community to Improve Mental Health Outcomes*: examined nine key areas where examples from countries outside the United States have paved a way for improved mental health services.

2020 *Crisis Services: Meeting Needs, Saving Lives*: built upon SAMHSA's Crisis Toolkit guidelines to help drive forward the need for a capacity for crisis services along its own continuum that is interconnected and equally accessible to diverse population.

In the years since the first paper in the *Beyond Beds* series was published, its tenets both reflected the national conversation and helped NASMHPD and state mental health leaders shape policy and planning. In 2021, the *Beyond Beds* dialogue calling for a complete continuum of psychiatric care is as important as ever, only it comes with the lessons learned from COVID-19 and a strong emphasis on continuing to enhance the crisis continuum of care. There are several reasons for this emphasis on prevention and crisis response that make these key considerations far beyond simply relying on "beds."

This paper, *Ready to Respond*, is the umbrella paper for the 2021 NASMHPD technical assistance coalition series and aims to lay out a roadmap for the years to come as we emerge from the pandemic and need, more than ever, a full continuum of psychiatric care. Although there are daily discussions

about crisis services, a complete continuum will need to incorporate integrated and interconnected services that can both prevent crisis and respond to them, as well as provide supports for individuals beyond crises. It will be critical to look ahead beyond COVID-19 and beyond inpatient psychiatric beds toward building out an improved, accessible and sustainable mental health service continuum that can be equally available across all demographics, in rural and urban regions, to meet what undoubtedly will remain growing demand.⁶ The paper outlines the current landscape of the crisis response continuum and overall behavioral health system demands and finishes highlighting seven key priority areas for consideration.

Catalysts for Enhanced Crisis Response as a Critical Aspect of the Psychiatric Continuum of Care

The activity of SAMHSA and NASMHPD along with countless interested stakeholders in mental health outcomes have been galvanized to pay attention and fund a growing number of programs for persons in behavioral health systems. Advocacy has played a key role, though demand for these services has also been borne out of the many failures and tragic negative outcomes seen across a depleted and fragmented mental health system. As such, several themes have been prominent in pushing forward a dialogue around crisis services that pre-date but have been heightened by COVID-19. Although the impetus for current system change is multifactorial, below six major themes are delineated as catalysts that have spawned planning for enhanced crisis response systems as a key aspect of the psychiatric continuum of care (Figure 2).

One major theme that has catalyzed a discussion regarding crisis services as a vital part of the continuum of care is the rise in suicide rates across the country. Data from the American Foundation of Suicide Prevention showed 48,344 individuals died by suicide in America in 2018, and there were a recorded 1.4 million suicide attempts.⁷ According to the Centers for Disease Control and Prevention (CDC), suicide was the second leading cause of death after accidents for individuals age 10 to 34 in 2019 and the fourth leading cause of death for individuals age 35 to 54.⁸ Suicide rates between 2007 and 2017 increased 56% among people ages 10 to 24 years.⁹ In response, the U.S. Surgeon General issued a report in 2021 outlining a national strategy for suicide prevention.¹⁰

Figure 2: Catalysts Driving Toward Enhanced Crisis Response Systems

1. Suicide rates
2. COVID-19 and its impacts
3. Opioid overdose deaths
4. Jail diversion efforts and need to revisit the role of law enforcement in crisis encounters
5. Need for prevention and augmented services for children and adolescents with serious emotional disturbances
6. Litigation and regulation

Relatedly, as COVID-19's impact was increasingly causing distress, suicide prevention advocates had been pursuing a way to simplify the use of the National Suicide Prevention Lifeline. In July 2020, the Federal Communications Commission (FCC) announced that 988 would become Lifeline's designated number. This decision has jump-started a movement to help achieve its promise starting in July 2022. Many believe the need for a simplified crisis line access point could not be coming soon enough. Yet, as noted below, there remain challenges to achieving its implementation that will require ongoing diligent effort.

The second catalyst for change has been the impact of the COVID-19 pandemic on mental health. Although initial reports indicate there was no increase in overall suicide deaths during the pandemic,¹¹ survey data has shown more alarming rates of distress. The CDC's Monthly Morbidity and Mortality Weekly Report showed that in June 2020, the U.S. adult population reported experiencing increased levels of mental health symptoms including anxiety, depression, trauma-related symptoms, increased substance use and increased reports of serious suicidal ideation compared to earlier pre-pandemic data.¹² These findings were heightened for specific populations, including Black and Hispanic populations, essential workers and younger respondents.^{13,14} Additionally, surveillance data has shown increased emergency department visits for youth between ages 12-17, especially girls, presenting with suspected suicide attempts.¹⁵ Reger and colleagues noted that although there may be a "pulling-together" of additional supports that could reduce suicide risk post-disaster, they point to several factors that could increase the risk of suicides in the wake of the pandemic.¹⁶ This includes the economic strain resulting from closed business, cancelled events and other economic downturns, social isolation, decreased access to community and religious supports, barriers to mental health treatment, illness and exacerbated medical problems, increased national anxiety, suicide rates among health care professionals, increased firearm sales, and shifting suicide rates across seasons. Thus, overall, as we move through and beyond the pandemic, attention to suicide prevention is a key component of needed services going forward.

The opioid crisis and the growing number of opioid overdose deaths represents a third catalyst for crisis service development. The increasing number of opioid overdose fatalities over the last half-decade or more created a need for intensive authorizations for funding through the State Targeted Response and subsequent Statewide Opioid Response discretionary grants and subsequent similar funding streams.^{17,18} Although states were finally seeing some improvements in opioid overdose death rates through these funding initiatives and other avenues, with the impact of COVID-19, the overdose numbers are sadly on the rise again and efforts must be redoubled to get ahead of those curves that have contributed to reduced life expectancy of younger populations.¹⁹ Methamphetamine associated deaths are also on the rise, which requires other specialized interventions.²⁰ The use of substances overall has increased while the percentage of persons of all ages receiving treatment has not.²¹

A fourth catalyst for change that produced some of the current press for system expansion is the ever-increasing attention on jail diversion. It has long been recognized that individuals with mental

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.

illness and substance use disorders are over-represented in the criminal-legal system and juvenile justice system. In 2006, Munetz and Griffin proposed a strategy that emphasized the need to identify and divert individuals from criminal processes along multiple points of interception coalescing at five stages, from law enforcement contact, to courts to reentry and community probation or parole supervision, which became known as the Sequential Intercept Model.²² In 2017, a sixth intercept, Intercept 0, was added with recognition that a more robust behavioral health crisis system might offer

opportunities for deflection and diversion from arrest altogether.²³ The Sequential Intercept Model was codified into the 21st Century Cures act, landmark mental health Federal legislation signed into law in 2016, driving grant programs and other initiatives.²⁴ At the same time, the Stepping Up initiative has helped county leaders and other stakeholders examine and reduce numbers of individuals with mental illness from jails.²⁵ In the wake of the murder of George Floyd, Breonna Taylor and others, anger over the disproportionate killing of black and brown people by police was raised to a feverish pitch, with one author calling the impact on emerging adults the “crisis within a crisis.”²⁶ Resultant cries to “defund police” and to find better alternatives to manage crisis than a law enforcement response have contributed to re-examining partnerships and responses that can minimize police contact and maximize alternative approaches to managing community members in distress. Mobile crisis responses with alternative responders are a key part of these ideas. Examples such as the CAHOOTS model out of Oregon have gained increased attention for their crisis work uses models outside of police response.^{27,28} A report by The Center for Law and Policy examined mobile response for youth with mental health issues and proposed key principles for effective mobile response programs as an alternative to law enforcement as first responders.²⁹ The key principles include ensuring responses do not include law enforcement, responders shouldn’t always need professional degrees and should include peers and that the services should be reimbursable from Medicaid to promote equity. At the same time as the need to reduce excessive use of force in crisis response, the importance of jail diversion continues.

A fifth catalyst for change is with regard to children and adolescents and the growing and alarming trends for youth waiting in emergency rooms for psychiatric inpatient care.³⁰ Many states have faced litigation for failing to meet Medicaid’s statutory Early and Periodic Screening, Diagnosis and Treatment (EPSDT) requirement for Medicaid beneficiaries.³¹ This trend has shifted planning to create an intensive expansion of service arrays in many states to attempt to meet the needs of youth with serious emotional disturbances (SED). There is a large overlap with youth in the child welfare systems and the 2018 Family First Prevention Services Act now requires that treatment centers, known as Qualified Residential Treatment Programs for youth with psychological, behavioral or substance use challenges, must provide trauma-informed care and licensed staff that is more akin to a treatment model than a model that provides only structure and housing for youth involved in the child welfare system.³² Often, EPSDT lawsuits incorporate an additional focus on youth involved in the child welfare and/or juvenile justice systems, given the propensity of those youth to be likely to have serious emotional disturbances stemming from any number of conditions. And remedies for these cases often include intensive mobile crisis services and follow up supports,³³ which again is a path that leads to expanded crisis services for Medicaid eligible youth. Although these are youth-focused programs, their design creates other discussion that can support adults in crisis as well as other populations, including those with complex needs such as those with intellectual and developmental disabilities.

Media reports and litigation against states and jurisdictions have been a sixth catalyst for change. Pivotal cases have called for remedies for waitlists of individuals found incompetent to stand trial waiting in jail^{34,35} and other forensic populations.³⁶ Recent cases in Washington³⁷ and New Hampshire³⁸ have sided with plaintiffs against the states related to the boarding of patients in emergency departments with findings that states are failing to meet constitutional standards by leaving individuals languishing in emergency departments when they have been determined in need of psychiatric hospitalization.³⁹ The case in Washington supported advocacy for additional funding for more robust services with the state

legislature.⁴⁰ In addition, *Olmstead v. L.C.* (1999), a case often used in litigation to drive improved services, has catalyzed shifts for state mental health systems to help prioritize the terms of the Americans with Disabilities Act by providing adequate constitutional protections for persons with disabilities that require them to be served in the least restrictive environments and appropriate community-based services.⁴¹ These cases dovetail the Final Rule that was set forth in 2014 related to Home and Community-Based Services Waivers, that was aimed to enhance the quality of these services and provide additional protections such that Medicaid beneficiaries receiving these services have full access to the benefits of community living.⁴² Home and community based services rules and associated new dollars that are being made available through the American Rescue Plan Act related to COVID-19 have fostered states to spend resources building out these types of services.

Together, these examples of change drivers have called for system transformation and development of a more accessible and complete psychiatric crisis care continuum. Many of these issues predated COVID-19 and culminated in February 2020 in the release by SAMHSA of the *National Guidelines for Behavioral Health Crisis Care-Best Practice Toolkit*,⁴³ which called for practices that would yield better outcomes for individuals in acute need while reducing unnecessary hospitalizations and arrests. This was followed by the 2020 series of *Crisis Services: Meeting Needs, Saving Lives*⁴⁴ as well as the National Council for Wellbeing and the Group for the Advancement of Psychiatry's *Roadmap to the Ideal Crisis System*.⁴⁵ Unimaginable as it was, however, as the original SAMHSA Toolkit was being written, on January 20, 2020, the first case of COVID-19 infection was reported in the United States,⁴⁶ and by the time of *The Toolkit's* release, the world was facing a global pandemic.

Much has happened since those first COVID-19 cases were identified. As the virus spread around the world, everything as society knew it quickly and forever changed. The emotional toll of this pandemic, comingled with a tragic spotlight on the murder of George Floyd and other Black and Brown men at the hands of police as well as general healthcare disparities seen in the pandemic's impacts, has no doubt further driven the need for preparedness and availability of adept crisis responses.

As the world sorts through the massive disruption and loss of life caused in this moment, policy makers in mental health and other public services are called to the task of developing and building back a sustainable and improved mental health continuum of care that is more adept at meeting the needs of more people, including those with more complex presentations. Too many people with serious mental illness remain homeless, unemployed or incarcerated with insufficient access to services. With the roll out of vaccines comes the hope of having COVID-19 immunity more widespread including for vulnerable populations. Yet, the Delta variant has produced a trail of viral spread and new questions. With all these factors coalescing, there is so much to do to help ensure that access to mental health and substance use services are robust and immediate. The calls for enhanced crisis services that arose prior to the

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.

pandemic have only been heightened. It is important to take stock and continue pursuit of policies and programs to realize improved outcomes for all.

Taking Stock: Key Areas of Focus that Will Shape Future Outcomes

Moving from Beyond Beds to Beyond Crises and to a Full Continuum of Psychiatric Care

NASMHPD polled state mental health leaders in June 2021 asking for their perspectives in reviewing the 10 key original recommendations from the 2017 *Beyond Beds* paper. A self-selected group of 25 respondents provided feedback on which of the recommendations had yielded accomplishments and which were needed to be prioritized in the coming years to ensure an infrastructure of a continuum of mental health services achieved (Table 1). In addition, this same group of state leaders who are enthusiastically and diligently working on the development of the 988 infrastructure were also forthcoming about barriers that exist today that will need additional attention and focus (Table 2).

Table 1: Top Three *Beyond Beds* Recommendations from State Mental Health Leaders

	Recommendations where significant progress has been made	Recommendations where more progress is needed	Recommendations more important after COVID-19
First	The Vital Continuum	The Vital Continuum	Workforce
Second	Criminal and Juvenile Justice Diversion	Workforce	The Vital Continuum
Third	Partnerships	Criminal and Juvenile Justice	Technology

Table 2: Identified Barriers to 988 Implementation from State Mental Health Leaders

	Count	% of respondents
Workforce shortages	16	64%
Rural/geographic concerns for mobile crisis	13	52%
Technology/IT	9	36%
Not enough crisis system infrastructure	9	36%
Lack of funding	8	32%
Meeting needs of diverse populations and geographies	6	24%
Insufficient crisis bed capacity	4	16%
Ensuring 24/7 availability	3	12%
Limited collaboration across law enforcement, emergency medical and mental health systems	3	12%
Legislative barriers	2	8%

The results of this informal survey of state mental health leaders is telling and helps set the stage for areas of emphasis needed as states navigate new budgets and plan for future directions. Other information available about the public's well-being further helps inform priorities.

Surveys Regarding the Emotional Impact of the COVID-19 Pandemic

As leaders in behavioral health systems examine what is needed for the future, part of planning must include information about the emotional impact of COVID-19. In March 2020, Brooks and colleagues published a rapid review of the psychological impacts of quarantine from prior outbreaks such as SARS, Ebola, and the H1N1 influenza pandemics.⁴⁷ Their findings synthesized 24 papers examining these issues and found negative emotional effects including post-traumatic stress symptoms, confusion, and anger especially related to longer quarantine duration, fears of infection, boredom, frustration, insufficient information and supplies, and financial strain. During the COVID-19 pandemic, similar findings were seen, including from the CDC showing marked increases in mental distress and suicidal ideation compared to the previous year.⁴⁸

Regular household "pulse" surveys (HPS) of persons across the U.S. over the age of 18 during the pandemic were conducted through the CDC in partnership with the U.S. Census Bureau. A report on the findings of the HPS data showed that between August 19, 2020 and February 1, 2021, there were significant increases (from 36.4% to 41.5%) of adults who reported symptoms of anxiety or depressive disorders during the past seven days.⁴⁹ This increase in symptom reporting also corresponded with increased reports of needing mental health counseling but had not received it (9.2% to 11.7%), with findings of the greatest increases for those individuals between 18 and 29 years old and those with less than a high school education.

New data is consistently emerging from around the world looking at the emotional impact of the pandemic on populations. For example, Pieh and colleagues⁵⁰ examined the mental health of high school students in Austria during social distancing and remote schooling and found, compared to similar data from 2018, increased symptoms of depression, anxiety, insomnia and disordered eating and suicidal ideation. One third of respondents also reported suicidal thoughts. In addition, the authors found increased smartphone use associated with worse mental health.⁵¹ Findings in adults treated for high blood pressure showed that the stress and anxiety during the COVID-19 pandemic lead to a worsening of blood pressure control.⁵² A study by the American Psychological Association reported that more than 50% of respondents reported "re-entry anxiety," which was a term used to explain the emotional distress associated with opening back up and returning to work and social events after so many months of staying at home.⁵³

Prior studies also showed healthcare workers reporting post-traumatic stress symptoms during outbreaks that pre-dated COVID-19, with depression, insomnia and anxiety sometimes lasting for one to three years afterward.⁵⁴ Frontline workers dealing with COVID-19 patients directly may be particularly impacted emotionally with burnout.⁵⁵ The behavioral health workforce has had similar strains in dealing with the demand for services in the face of limited supplies and numerous resource challenges.⁵⁶ More recent data with responses from over 26,000 state, tribal, local and territorial public health workers suggest that 53% reported symptoms of at least one mental health condition in the prior two weeks, with worse symptoms for those who did not take time off work or worked more than 41 hours per week.⁵⁷ Although suicide rate data has not yet shown marked increases, this is an ongoing concern.

Taken together, these trends inform policy makers that the need is now and the demand for mental health services is likely to rise further.

Diversity, Equity and Inclusion Call to Action

Disparities in how COVID-19 impacted populations galvanized action to more intentionally focus on health disparities. History teaches us that the disparities in how diseases spread is not new (Figure 3).^{58,59,60} The magnitude of COVID-19's impact was, however, new to this century, and called out more about potential vulnerabilities, including those to specific underserved populations. In addition to how COVID-19 impacted persons of color and other ethnic groups, in the field of behavioral health, there were other disparities of note. Studies found individuals with substance use disorders⁶¹, serious mental illness⁶² and intellectual and developmental disabilities⁶³ have been at disproportionate risk of acquiring COVID-19 and its related impacts.

In the context of increased awareness of the uneven distribution of COVID-19, in May 2020, the murder of George Floyd created outrage and protests that transformed the dialogue to an even broader one related to diversity, equity and inclusion across the board. State and federal leaders have focused on more inclusion in hiring key positions with diverse backgrounds at the highest levels. The election of the Biden-Harris Administration embodies this priority, with Vice President Harris representing the first person of color-- and the first woman-- to be elected to this powerful position. Diversity has been a hallmark of President Biden's selection of key leaders. Some states have mirrored these activities.

In addition to leadership selection, policies and practices have focused on issues related to diversity and equity. President Biden issued an executive order on January 21, 2021, titled *Ensuring an Equitable Pandemic Response and Recovery*, which established a COVID-19 Health Equity Task Force to provide government-wide efforts to "identify and eliminate health and social disparities that result in disproportionately higher rates of exposure, illness, hospitalization and death related to COVID-19."⁶⁴ This has been true among behavioral health leaders and in behavioral health policy making around the country. On behalf of SAMHSA, the 2020 Compendium of technical assistance coalition papers, *Crisis Services: Meeting Needs, Saving Lives*,⁶⁵ had a focus on structural racism and the need for health equity. One of its papers solely focused on how crisis services needed to attend to diverse populations if crisis services were to truly be able to serve anyone, at any time, as directed in the SAMHSA Best Practice Toolkit.⁶⁶

The importance of attending to diversity and equity is not only just the right thing to do. It is increasing clear that outcomes for mental illness, substance use disorders and serious emotional disturbances are tied to social determinants of health.⁶⁷ The social determinants themselves are clearly impacting populations such as persons of color or Native Americans disproportionately. Not only were these

Figure 3: Lessons from History on Disparities in Health Outcomes During Prior Pandemics

Studies examining previous pandemics indicate that persons of the lowest socioeconomic status had the highest mortality rates from pandemics in 1918 and in 2009. Although there was some indication that there were two waves, with the first hitting the poor, and the second hitting the rich. Another study of the influenza pandemic of 1918 showed that Black Americans had lower morbidity but higher case fatality rates for unclear reasons.

(Mamelund et al 2019; Mamelund et al. 2018; Økland et al 2019)

populations disproportionately impacted by COVID-19,⁶⁸ but data on the emotional impact of COVID-19 seen in the health pulse surveys also show these differences.⁶⁹ Suicide rates, drug overdoses and access to care all must therefore be priorities for populations for whom there are differences and disadvantages today.

The Promise of 988 and Crisis Best Practices to Service Anyone, Anywhere, at Anytime

As described above, in July 2020, the FCC approved rules that established 988 as the three-digit number that would serve as the national suicide prevention lifeline to aid callers to get access to supports and services.⁷⁰ This paved the way for the October 2020 passage of The National Suicide Hotline Designation Act, touted as a landmark piece of legislation that will change the landscape of crisis response. The signing of this suicide prevention bill was celebrated by many stakeholders, including diverse communities far and wide, such as LGBTQ+ communities,⁷¹ and has been celebrated as a way to reduce police violence toward persons of color by creating alternative pathways to respond to crisis.⁷²

There is a recognition that 988 is more than just a suicide prevention lifeline but an entry point for any needed crisis response for any type of behavioral health crisis including suicide, mental health, or youth in distress. The implementation of 988 and a robust crisis continuum of care will require vigilant stakeholder buy-in, appropriate funding, and infrastructure development.

Funding of the future of crisis services is an important area of consideration. In a report to Congress by the Medicaid and CHIP Payment Access Commission (MACPAC), a non-partisan legislative branch agency that provides policy and data analysis to make recommendations to Congress and the U.S. Department of Human Services, the Commission analyzed government datasets to create a series of recommendations regarding access and Medicaid payment of mental health services.⁷³ The authors highlighted the unmet need of mental health services, including that 50% of Medicaid beneficiaries with serious mental illness said they needed but did not receive treatment and that access to treatment is affected greatly by the extent of which states cover services and the willingness of providers to accept new Medicaid patients. It is estimated that one out of every four individuals with serious mental illness are covered by Medicaid, and one out of every six individuals with a substance use disorder,⁷⁴ and as such Medicaid remains a big player in the infrastructure of a robust behavioral health continuum of care.

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.

With regard to funding crisis services, many states are working toward legislation that taxes citizens to collect funding support 988 similar to how 911 is funded, with Virginia being the first state to pass such legislation.⁷⁵ NASMHPD has been working with state leaders to help in these efforts. In addition, since many crisis service recipients receive their behavioral health care through Medicaid or are individuals with serious mental illness or substance use disorders, SAMHSA and the Center for Medicaid and Medicare Services (CMS) have major roles in developing funding pathways. This includes significant set asides in federal block grant dollars, including those that are coming to the states via the American Rescue Plan Act (ARPA) as well as other funding mechanisms. Yet there will also be the need to engage

with private insurers and other funding streams to help ensure the success of crisis services, since they will be accessible to all.

Another consideration is that it is believed that the implementation of 988 will increase the demand for crisis services. Although Medicaid programs can play a critical role in financing them, states have little guidance on how to implement funding to support this work. To that end, MACPAC recommends that joint sub regulatory guidance from the federal government should address how Medicaid and CHIP can be used to fund a crisis continuum for beneficiaries experiencing mental health crises. An analysis published by Vikki Wachino and Natasha Camhi for the Well Being Trust provides five policy pathways through Medicaid, referred to in their paper as building blocks, in how Medicaid can help states pay for and build robust crisis systems. These include 1) expanding benefits to cover crisis services through state options, 2) using waiver authorities to increase access to home and community based services (HCBS), 3) using managed care delivery systems to provide crisis services, 4) expanding crisis services through 1115 demonstration waivers and 5) financing administrative spending for Medicaid beneficiaries in call centers.⁷⁶ These guiding recommendations may serve as a roadmap for states as they also balance funding coming in through the ARPA funds and the provisions for enhanced Home and Community Based Services (HCBS).

The expectation of the authorizing legislation for 988 is that it be operational by July 2022. As such, states are working to ensure that they are ready for the 988 launch. To help foster collaboration and inspire the development of 988 activities, SAMHSA, NASMHPD and other partners have helped develop a weekly virtual “Crisis Jam” that has been hosted through RI International, in partnership with the National Action Alliance for Suicide Prevention, the National Suicide Prevention Lifeline, Vibrant Emotional health and NASMHPD, where leaders from around the country inform each other on best practices and next steps for 988 roll out. Each week more than 200 individuals attend. As part of this effort, NASMHPD also helped launch #CrisisTalk,⁷⁷ which provides a wealth of information and news-type reports related to crisis services role out.

The promise of 988, envisions high call volumes responded to via crisis call centers with full GPS information on a caller’s location. Through this technology, call responders will help inform individuals about local behavioral health resources and be able to deploy a mobile crisis team if necessary.

Workforce Needs

A robust continuum of psychiatric care requires the workforce infrastructure to make it effective. There are major concerns that workforce shortages will impede the ability to respond to the tsunami of mental health needs. In 2018, the National Council for Mental Wellbeing Medical Directors Institute put forth a report titled *Psychiatric Shortages: Causes and Solutions*,⁷⁸ highlighting years of psychiatric workforce shortages and the need to expand care to integrated multi-disciplinary care teams to help ensure access to services. Direct care workers and direct support professionals have also been highlighted as a priority area of need.^{79,80,81} The General Accounting Office noted in 2001 of the need to attend to critical shortage areas of direct care workers, including those that work for older adults and others.⁸²

All levels of care in the continuum seem to be impacted, and in some places, staffing is at a critical level. Take Oregon, for example, where its state hospitals were found to be in dire conditions with more than 45% of its direct care staff taking leave, necessitating in the spring of 2021 the state to call in the National Guard to assist.⁸³

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.

Several states and legislators are attempting to create solutions to workforce shortages. For example, faced with new legislation that was expanding an autism benefit, Michigan worked to expand the availability of board-certified behavior analysts by expanding certification programs to ten universities throughout the state.⁸⁴ As another example, although the state declared a staffing crisis in its state hospitals, CareOregon is making a major investment of \$7.5 million in 25 behavioral health provider organizations to help them recruit and retain staff as part of the CareOregon Emergency Behavioral Health Workforce Stabilization Fund proposal.⁸⁵ In Congress, Representative Debbie Dingell (MI) proposed the Better Care Better Jobs Act to help stabilize and

expand the workforce providing home and community-based services.⁸⁶ These efforts are important steps forward. However, as noted by the survey of Commissioners outlined above, workforce shortages represent one of the most significant concerns for state mental health leaders and will remain a key priority area of focus in order to meet the demands for mental health services.

Advancing Technology

Expanding and strengthening telepractice was highlighted as another significant priority area in the Commissioners' survey. Even before the pandemic, the use of telepsychiatry was gaining traction and studies were showing positive outcomes.⁸⁷ In the massive transition to address the COVID-19 pandemic, the use of technology become an imperative. Mental health and substance use services saw remarkable shifts in care delivery to almost total video or telephonic use in order to facilitate access and social distancing related to the pandemic.⁸⁸ During the pandemic, the federal government assisted in the transition by supporting policies that helped to minimize disruptions to care delivery during the emergency declaration.⁸⁹ As the workforce got comfortable with virtual platforms, many organizations attempted to provide guidance regarding the provision of telepractices.⁹⁰ A review of the literature synthesized from international experiences highlighted practical guidance and the need to understand hybrid approaches in the post-COVID-19 world.⁹¹

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 virtual platforms helped maintain a specific level of service, certain areas where broadband access or for populations for whom access to cell phone minutes were more limited created disparities in access.⁹² In addition to these types of challenges, there have been ongoing questions about whether telephone-only services will yield the same payment structures as video-based clinical interventions.

More work is also needed to examine whether the shift to emphasize virtual technology over in-person over the long-term will have the same positive benefits it seems to have had during the crisis.

Key Areas for Priority in Behavioral Health Services Beyond COVID-19 and Beyond Beds

Mental health services are rapidly shifting and have proven both nimble and resilient in the face of unprecedented demands and a fluid environmental context with the emergence of COVID-19. At the same time, mental health and substance use challenges remain, and their development requires ongoing vigilance. Now is the time to be ready to respond to need and to anticipate avenues that can support a sustained, improved, and robust continuum of psychiatric care. The recommendations from the 2017 *Beyond Beds* remain relevant today. It is clear that psychiatric inpatient services, although necessary, are not sufficient as a single solution to the mental health needs of the population. In the COVID-19 recovery period, key priority recommendations must be highlighted-- some as spin offs from the 2017 recommendations, and some with a newer focus. Details surrounding these recommendations are delineated in this 2021 *Ready to Respond* compendium's individual technical assistance papers as outlined in Table 3. Each theme helps shape aspects of a reimagined sustainable and robust continuum of psychiatric care.

Table 3: 2021 NASMHPD *Ready to Respond* Compendium of Technical Assistance Coalition Papers

No.	Compendium Topics
1	Ready to Respond: Mental Health Beyond Crisis and COVID-19
2	Disaster Behavioral Health Through the Lens of COVID-19
3	Suicide Prevention and 988: Before, During and After COVID19
4	Law Enforcement and Crisis Services: Past Lessons for New Partnerships and the Future of 988
5	Strategies and Considerations for Providing a More Equitable Crisis Continuum for People of Color in the United States
6	The Effects of COVID-19 on Children, Youth and Families
7	Mental Health System Development in Rural and Remote Areas during COVID-19
8	Funding Opportunities for Expanding Crisis Stabilization Systems and Services
9	Technology's Acceleration in Behavioral Health: COVID, 988, Social Media, Treatment and More
10	Using Data to Manage State and Local-level Mental Health Crisis Services

Within this “Ready to Respond” framework, key areas of priority have emerged across the various topics. These priority policy recommendations are highlighted below:

1. Expand and achieve a full continuum of crisis services.

Through the crisis of the pandemic, a greater push for crisis response enhancement has been achieved. Important changes are on the horizon with the revamping of the National Suicide Prevention Lifeline number to an easy-to remember 3-digit number, 988, expanding the Lifeline network for better coverage across the states, and making investments in quality assurance to improve the provision of quality care. The Lifeline will provide expanded capacity for a surge of calls during any future disaster/emergency.

Given that the launch of 988 is less than a year ahead of this writing and the growing demands for improved responses from law enforcement and behavioral health supports, prioritization of the crisis work must continue. This will mean the expansion of interconnected lifeline centers, bringing together 911 and 988 activities, as well as the launch of an increased number of mobile crisis intervention (MCI) and mobile crisis services



(MCS) for persons of all ages. There is a need for increasing research and empirical evidence for what types of mobile response are best for which populations, what types of staffing models are ideal, and what roles behavioral health staff play when emergency medical services and law enforcement are each called to a scene. The role of peers and recovery coaches will need to be expanded and further refined for these services. Crisis text lines, peer warm lines and information about resources such as domestic violence, grief support, housing and employment services must all be available for callers to receive. High risk situations during a crisis, including working with armed individuals, though rare, must also be triaged addressed with the most appropriate and least restrictive interventions without compromising safety. And persons in crisis must be linked to care, whether its MAT for opioid use disorder, or psychotropic medications for acute psychotic conditions, there must be immediate access to evidence-based therapies available through the crisis network.

2. Rebuild and reboot a robust, diverse, and well-qualified workforce.

As noted above, burnout rates of frontline workers are profound, and the gaps in workforce seem to be at an all-time alarming rate. With the needs for mental health and substance use services on the rise, now is the time to regenerate a workforce that is ready, willing and able to serve in the public and private behavioral health systems and provide care for each other. Just as in the *Beyond Beds* recommendations, this includes expanding the workforce beyond the traditional professionals, integrating expanded roles for peer supports, recovery coaches and even lay staff to help support some of the infrastructure of services for individuals to help them remain. Highlighting the need for greater education and pay for direct care workers and direct support professionals is also going to be necessary to support the home and community-based services tenets. As the workforce is being developed, they will also need a greater intentional focus on their own well-being, and flexible job options such as flex schedules and virtual options where feasible. Working with schools to grow and develop workforce is another avenue that warrants further exploration, along with loan repayment programs and attention to health professional shortage area designations. Innovation to grow the workforce will be needed, and many states are already embarking on dialogue to implement new ideas along these lines.

*Rebuild and Reboot
a Robust
Workforce*



3. Expand telehealth practices while ensuring ongoing quality and access.

The pivot to the use of technology in response to the COVID-19 pandemic catalyzed major changes in the workplace that will likely never return to pre-COVID-19 operations. Technological advances in providing care will continue to require research and innovation as the technology develops still further. Hybrid approaches that allow for some in-person connections as well as telehealth activities need to be studied to help determine best practices for particular individuals, settings and conditions. Given the workforce challenges, the use of telehealth has allowed for expanded crisis responses in more remote

Expand Telehealth



areas. The potential for increasing broadband access to regions currently less served opens a myriad of possibilities for enhancements. Lessons learned from the COVID-19 experience should be taken to help shore up responses to future disasters, and future enhancements should be driven by data. Telehealth has proven lifesaving, both because it allowed for mitigation of viral spread at the height of the early pandemic outbreak, and because it helped keep people in mental health services who may have otherwise been at risk of decompensation or suicide. The effort now should be focused on how to sustain the most impactful aspects of telehealth and continue to enhance quality and access not as a replacement for all in-person services but as another quality tool in the array of services available.

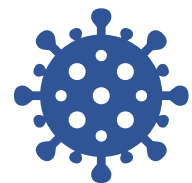
4. Foster integration of disaster behavioral health into emergency preparedness and response.

Although COVID-19 has caused immeasurable pain and loss, it has catalyzed opportunities to improve the behavioral health system's integration into emergency preparedness and to assist in future continuity of operations. Disaster behavioral health (DBH) should continue to be implemented with three immediate foci:

- Ensure that vulnerable populations with serious mental illness, serious emotional disturbances, substance use disorder, persons with intellectual and developmental disabilities, neurocognitive conditions and traumatic brain injuries who require additional supports are well served without disruption during emergencies.
- Coordination of DBH requires efforts to address the general emotional impacts of emergencies on the population as a whole.
- DBH activities should also center around serving the emotional needs of the public health and behavioral health workforce as a separate and focused effort.

Planning as part of disaster preparedness should include developing culturally and linguistically tailored messages to provide information and identify supports for diverse populations. The benefits of self-care, the skills of peers and peer navigators, the willingness of faith-based messengers and influencers, and the value of warmlines, telehealth and provider mutual aid agreements locally or with neighboring states became more evident during COVID-19, and these resources should be augmented. The SAMHSA Disaster Distress Helpline and Crisis Text Lines handled substantial increases in volume, reflecting anxiety and distress brought on by COVID-19's many uncertainties and the critical importance of these types of assets. Grants available through FEMA's Crisis Counseling Program (CCP) for short-term support to states and special grant opportunities⁹³ and increased Medicaid matching helped states to cover service needs related to COVID-19, and advocacy and access to these resources proved invaluable and should continue.

Emergency Preparedness



In 2019, *Beyond the Borders: Lessons from the International Community to Improve Mental Health Outcomes* examined the experience of other countries in responding to disaster and building sustained improvements in mental health services.⁹⁴ Similarly, Yox reviewed the lessons learned about global health, and called out some of the global health conceptualizations as placing priorities on improved health and achieving equity in health worldwide.⁹⁵ She describes work of the National Association of County and City Health Officials (NACCHO) and local health departments (LHDs) and the importance of focusing on global health, allowing and shifting to bidirectional learning so that those LHDs in the United States can also learn from the experiences of other countries in dealing with local health crises. She

notes that given the inherent risks of long-term impact of COVID-19 on social isolation, mental health and substance use the need to look beyond one's borders and continue to improve in a global sense is paramount. By focusing on global health, and examining physical and mental health simultaneously, there may continue to be evolving strategies that can foster greater healing and recovery from disasters.

5. Consider creative financial opportunities to maximize access to crisis response and other community-based mental health and substance use services with no wrong door.

Funding streams for crisis services will likely be needed from a variety of sources, including Medicaid, CHIP, general funds, new tax levies on 988 calls, federal discretionary grants such as block grant dollars, private insurers and more immediate funds coming through the American Rescue Plan Act. The challenge is that each of these sources of funding have their own mandates, limitations and requirements. They also are managed at state and local levels by different entities which can create barriers to uniform planning for a service that cuts across all sectors. Even outside of the traditional mental health and substance use state authorities, there is the need to serve individuals with intellectual and developmental disabilities, older adults, schools, child welfare, juvenile justice, criminal legal and court systems who send referrals either in a moment of crisis or as part of the full array of supports needed. This will include leveraging waiver options for Medicaid services to maximize federal dollars, as well as considering options to manage finances through population based initiatives such as health homes, accountable care organizations or managed type entities, as well as using demonstration opportunities for community level comprehensive services such as in the Certified Community Behavioral Health Center Model. Opportunities for creative options exist for states to help serve individuals that did not exist previously, and policymakers therefore are given a golden opportunity to use the funds wisely.

Financial Opportunities



6. Focus intentionally on diversity, equity and inclusion to reduce disparities in mental health outcomes.

Tragically, disparities in healthcare have not dissipated. In fact, the impact of COVID-19 has made them only more apparent. Leadership at the highest level of the federal government has recognized the critical importance of ensuring diversity of representation and intentional efforts to study health outcomes from an equity lens. In the space of crisis services and the broader continuum of psychiatric services for all ages, attending to diverse populations and their unique needs is critical. The needs of Black and Brown persons, Latinos, American Indian and Alaska Natives, among individuals with serious mental illness or other behavioral health type condition, just to name a few, require and deserve targeted approaches to eliminate the disparities in mental health outcomes such as suicide rates, overdose rates, child welfare removals, and others that can lead to downstream consequences and impact generations. Policymakers should take every possible action to eliminate needless tragic outcomes associated with law enforcement encounters with persons of color and persons with mental illness that all too often are reported. Still, it is important to recognize that law enforcement will remain a partner in the crisis response system, and therefore efforts will be needed to engage them and focus those responses on the right situations and with attention to equity in access to jail diversion and reduced use of force as much as possible. Equitable, accessible, and just quality care must be front and center and cultural humility should enter service delivery. Much work is needed to reduce disparities. Calling these issues out is only the first step.

Focus on diversity, equity and inclusion



7. Enhance interconnectedness with other systems and across borders for improved global responses.

State mental health authorities have a unique role to play in expanding the crisis continuum, but they cannot do this in isolation. Collaborations are needed and bringing in stakeholders as advisors in program development aligns with federal funding requirements, such as is seen in mental health advisory bodies at state and local leadership levels. Collaborations between behavioral health and public health has been critical in addressing the COVID-19 pandemic and brought out the need to integrate these efforts in a sustainable way. As noted above, global health now has meaning and relevance to the human experience. Shifts away from traditional law enforcement responses in many cases, and ongoing needs of jail diversion and reentry supports, juvenile justice diversion remain key priority areas. Work must continue building bridges between child welfare, schools, and children’s behavioral health services. Local hospitals must be interconnected with community-based services. Persons with substance use disorders require warm handoffs and MAT must be available because it can literally save lives. Persons with traumatic brain injuries, intellectual and developmental disabilities and other challenges often appear in the behavioral health systems. Given these needs, establishing and enhancing interconnectedness has never been more important. Network analyses should demand policy makers to make sure that they have all the partners at the table and that they get input from various perspectives to roll out the best services possible.

*Interconnectedness for
Global Responses*



Conclusions

Although there have been many advances in improving mental illness outcomes, too many people with serious mental illness, serious emotional disorders, and co-occurring substance use disorders are still waiting too long to receive needed services. Too many are homeless, too many are being arrested, are incarcerated or in the juvenile justice settings, too many are overdosing and dying by suicide. With COVID-19 so many lives have been lost, and many people are in need of emotional support. Now, as COVID-19 vaccines roll out, and new funding is being distributed, there is hope on the horizon. Yet, while the virus remains present, there are even broader population mental health needs that will require immediate access through no wrong door policies. The daily dialogues are replete with ideas about how to build crisis services along a continuum. Looking beyond COVID-19 and beyond crisis, there continues to be a need for interventions across a continuum of care, the funding to support them, and a workforce to deliver them. *Ready to Respond* aims to provide a level-setting overview of the current landscape and highlights areas needed for prioritization. The resilience of our communities is profoundly humbling given the individual and collective experiences throughout this pandemic. Taking that strength forward, there is no better time than now to collaboratively pursue improved services for better outcomes.

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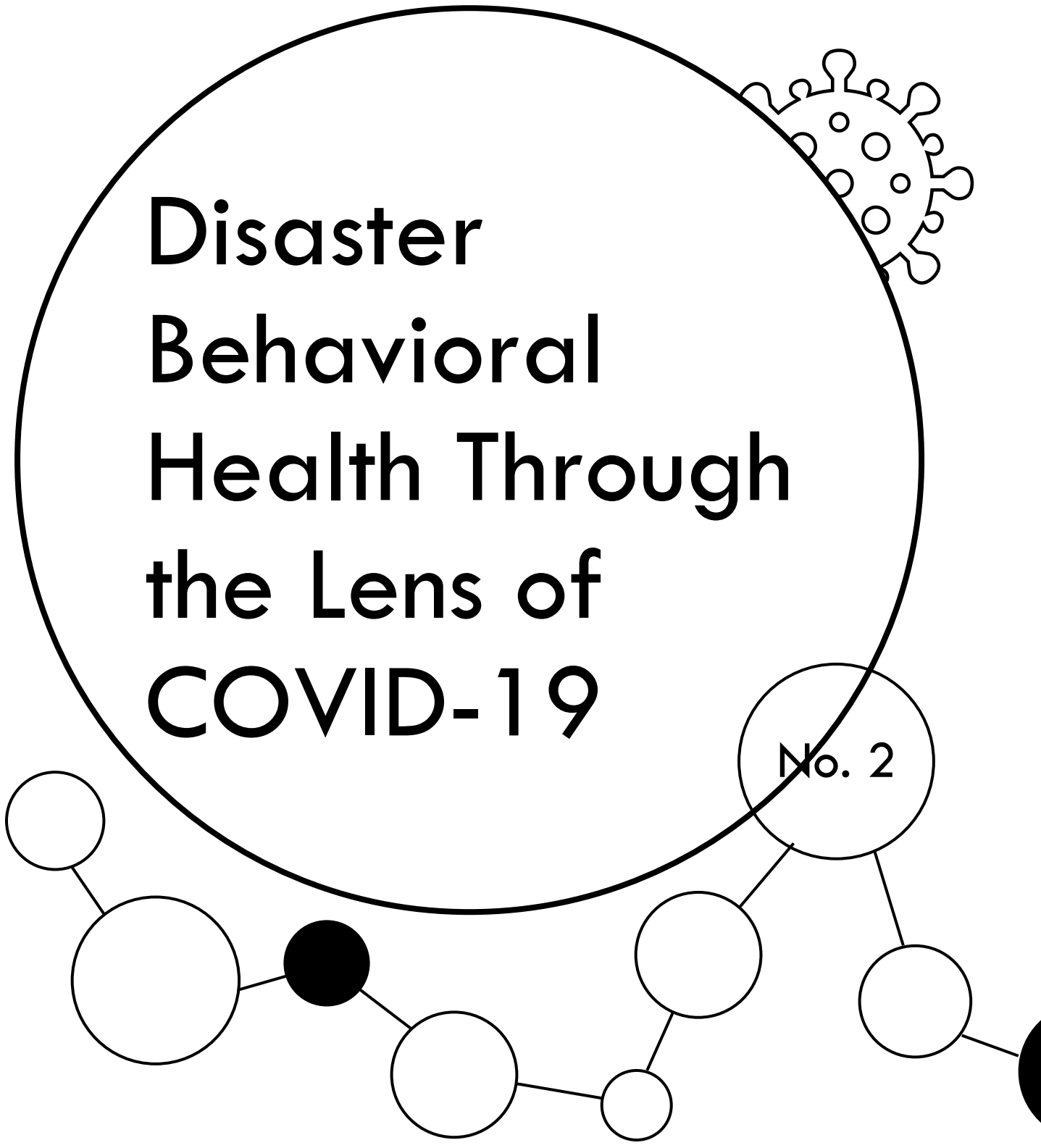
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Disaster Behavioral Health Through the Lens of COVID-19

No. 2

NASMHPD

Ready to Respond:
Mental Health Beyond Crisis and COVID-19

September 2021

Disaster Behavioral Health through the Lens of COVID-19

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***Second in the 2021 Ready to Respond Series of Ten Technical Assistance Briefs
focused on Beyond Beds, Reimagining a Sustainable and Robust Continuum of
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National Association of State Mental Health Program Directors

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September 2021

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Recommended Citation:

Pinals, D. A., Stephenson, A.H. (2021). *Disaster Behavioral Health Through the lens of COVID-19*. Technical Assistance Collaborative Paper No. 2. Alexandria, VA: National Association of State Mental Health Program Directors.

This work was developed under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS283201200021I/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

Abstract:

Disaster planning and response in the U.S. is structured by the National Incident Management System (NIMS) that focuses on the safety and protection of life, assets, and the environment. Additionally, the Federal Emergency Management Agency (FEMA) issues specific guidance related to such planning and response. Part of this planning includes the need to attend to the emotional well-being of those impacted by disasters, as well as the need to ensure continuity of operations and access to behavioral health care during emergencies. COVID-19 resulted in a declaration of emergency and by early 2020 was codified as a global pandemic. Unlike a more common, local, or sudden disaster emergency such as a tornado or an explosion, COVID-19 was global and long-term. It overwhelmed health care systems, caused the death of millions, created economic and social disruption around the world, and dramatically changed life as we knew it. From this experience, health disparities and the unique needs of public behavioral health populations became increasingly apparent. Additionally, the human toll from COVID-19 and the resultant need for expanded behavioral health crisis response suggests there are lessons to be learned from the widespread loss, quarantine, and social shifts to connections via technology. The pandemic also highlighted some of the progress that has occurred over the last several decades related to incorporating behavioral health responses into overall emergency preparedness. This paper reviews the history and framework of emergency planning and response and addresses aspects related to COVID-19. Recommendations for how best to incorporate behavioral health responses into future disaster emergency planning are offered.

Highlights:

- Emergency preparedness continues to evolve, integrating disaster behavioral health planning into overall preparedness.
- COVID-19 highlighted gaps in planning for epidemics and pandemics, including disaster behavioral health.
- Disparities in outcomes from COVID-19 and its impact on minority populations requires an intentional focus on health equity in emergency management.

Recommendations for the post-COVID-19 future:

1. Bolster the integration of disaster behavioral health into public health emergency preparedness and response.
2. Attend to health equity with specific efforts focused on the needs of high-risk populations.
3. Conduct mass psychological distress screenings and opportunities to provide emotional support.
4. Continue to promote behavioral health surveillance and research.
5. Foster communications focused on behavioral health needs.
6. Attend to the mental health of health care workers and responders.
7. Continue to build telehealth capacity.
8. Continue to foster training on aspects of disaster behavioral health.
9. Maximize continuity and access to treatment for behavioral health populations.
10. Continue efforts to expand and develop a robust crisis care system.

Emergency planning and response in the U.S. is structured by the National Incident Management System (NIMS), which focuses on the safety and protection of life, assets, and the environment. Guidance for this structure was established first in 2004 by the Federal Emergency Management Agency (FEMA) within the U.S. Department of Homeland Security.¹ The COVID-19 pandemic presented new challenges in all areas related to emergency planning and response. Unlike a more common, local, or sudden disaster emergency such as a tornado or an explosion, COVID-19 ultimately resulted in a declaration of emergency in all states and territories and by early 2020 was codified as a global pandemic. It overwhelmed health care systems, caused the death of millions and economic and social disruption around the world, and dramatically changed life as we knew it. Behavioral health systems were not spared. Public behavioral health systems, which not only serve the public behavioral health needs, but as state mental health authorities must attend to the emotional needs of the entire population, were especially impacted. This technical assistance paper focuses on Disaster Behavioral Health through this newly emerged COVID-19 lens and with thoughts for future planning and preparedness.

Coronavirus disease 2019 (COVID-19) is an infectious disease caused by the novel coronavirus SARS-CoV-2. The initial lack of immunity caused it to spread rapidly throughout the world causing millions to become ill and die.

Overview of Disaster Preparedness

Three major components of emergency management are: an **Emergency Operations Plan (EOP)** that is utilized to prepare for and respond to an emergency; an **Incident Command System (ICS)** which is a management structure that defines who is in charge (Incident Commander), who reports to whom and who has responsibility for overseeing duties related to Operations, Planning, Logistics, and Administration/Finance; and a **Continuity of Operation Plan (COOP)** that is typically activated in order to assist the agency with reconstituting or continuing regular operations. All federal and state agencies are required to develop EOPs using an “all-hazards” approach, meaning they are sufficiently flexible to address a full spectrum of emergencies or disasters, including man-made emergencies (e.g. chemical spills, explosions, chemical or biological attacks, nuclear blasts, plane crashes) and naturally occurring disasters/emergencies (e.g. tornadoes, hurricanes, floods, viruses, toxins). EOPs must also include planning for pandemic influenza, given the experience of the 1918 Pandemic and the expectation that one would emerge. An EOP is a requirement for government agencies but should also be a practice for all other organizations and businesses. It should be noted that much of the initial response is at the local level.

The authors of this technical assistance paper have a combined 40 plus years of experience in state government and disaster preparedness and response. Much of the content of this report is drawn from this experience in the field.

The COVID-19 pandemic is a unique type of emergency because it necessitated all five phases of the emergency management planning cycle to be addressed virtually simultaneously rather than one phase at a time. **Table 1 depicts these five phases and how they took place during COVID-19.**

Table 1: Five phases of emergency management planning cycle and COVID-19 response

Phase	Description	Sample COVID-19 response
1. Preparedness	Includes emergency preparedness plans to save lives and minimize damage that can occur during a disaster.	<ul style="list-style-type: none"> • Developed knowledge base of COVID-19 symptoms; • Acquired supplies and pharmaceuticals.
2. Prevention	<p>Activities to increase the community's ability to respond when a disaster occurs. This can include:</p> <ul style="list-style-type: none"> • deterrence operations and surveillance, • assessing the hazards, risks and vulnerabilities, • backing up information, • developing mutual aid agreements, • training for both response personnel and concerned citizens, • conducting disaster exercises to reinforce training and test capabilities, and • presenting all-hazards education campaigns. 	<ul style="list-style-type: none"> • Developed pandemic influenza plans; • Moved vaccines through the approval process; • Current vaccination efforts.
3. Mitigation	Putting in place measures that prevent an emergency, reduce the chance of an emergency happening, or reduce the damaging effects of unavoidable emergencies. This phase involves developing policies to reduce risks to people and property during a disaster and determining which groups are most at risk and what resources are needed.	<ul style="list-style-type: none"> • Emphasis and orders for consistent and correct use of masks, physical distancing and procedures for infection control; • Contact tracing in combination with isolation and quarantine; • Identification of seniors and some minority populations as being at greater risk.
4. Response	Activating the emergency operations plans and taking actions aimed at saving lives, reducing economic losses, and alleviating suffering.	<ul style="list-style-type: none"> • Deployment of personnel, information, protective equipment; • Activation of the Strategic National Stockpile; • COVID-19 vaccinations messaging regarding its efficacy and safety, distribution and administration.
5. Recovery	Actions taken to return a community to normal or near-normal conditions.	<ul style="list-style-type: none"> • Returning to the workplace; • Relaxation of mask mandates.

Activating an **Incident Command System (ICS)** provides a flexible, yet standardized core mechanism for coordinated and collaborative incident management internally, and particularly when multiple agencies,

organizations or jurisdictions are involved thus requiring cross-jurisdictional coordination. The ICS is designed to enable effective, efficient incident management by integrating a combination of facilities, equipment, personnel, procedures, and communications operating within a common organizational structure. ICS enables incident managers to identify key concerns associated with the incident—often under urgent conditions—without sacrificing attention to any component of the command system or the response. It represents organizational "best practices" and, as an element of the Command and Management Component of NIMS, has become the standard for emergency management across the country.²

A **Continuity of Operations Plan (COOP)** is a companion plan to an EOP. It establishes policy and guidance ensuring that an organization can continue critical functions in the event of a disaster. In order to achieve that goal, the organizations begin plan development by identifying their essential functions and further developing it ensure that those functions can be continued throughout, or resumed rapidly after, a disruption of normal activities. The overarching continuity requirements include:

1. Orders of succession – who takes over if leadership are unavailable or unable to execute their duties;
2. Delegations of authority – identification, by position, of the authorities for making policy determinations and decisions at all levels and at all other organizational locations;
3. Continuity facilities – if necessary, personnel and resources are relocated to an alternate location until operations return to normal or are directed to work from home;
4. Continuity communications – keep communications systems operational and provide the capability to perform essential functions internally and remotely as needed;
5. Vital records management – identification, protection and ready availability of electronic and hard copy documents as well as hardware, software and equipment needed to support essential functions during a continuity situation;
6. Human capital – ICS and/or COOP assigned employees and other special categories of employees who are activated to perform assigned response duties;
7. Tests, training, and exercises (TT&E) – drills or exercises conducted to ensure that plans can support the continued execution of essential functions throughout the duration of a continuity event;
8. Devolution of control and direction – capability to transfer authority for essential functions from primary operating staff and facilities to other employees and facilities; and
9. Reconstitution – the process by which surviving and/or replacement personnel resume normal organization operations from the original or replacement primary operating facility.

The pandemic has been so disruptive to most government agencies and businesses for such a prolonged period that they have been utilizing both their EOPs and their COOPs simultaneously throughout the pandemic.³

Functions of Government Agencies in Disaster Response

During an emergency FEMA's function is to serve in a support role to other federal and state government agencies overwhelmed by disaster. For a biological emergency FEMA would support the Department of Health and Human Services (DHHS) and, if needed, state health departments. However,

on March 19, 2020, FEMA’s role in the pandemic response was changed by the White House Coronavirus Task Force from supporting DHHS, which was designated as the initial lead federal agency for the COVID-19 pandemic response, to coordinating the Whole-of-Government response to the pandemic. In his testimony to Congress on July 24, 2020, the FEMA Administrator, Peter Gaynor, explained that for the first time in U.S. history the entire nation was in a state of emergency. There were 114 concurrent Major Disaster Declarations —one or more in every state and the District of Columbia, five territories and the Seminole Tribe of Florida. The scale of this historic event required FEMA to adapt its response practices and workforce posture to both respond to COVID-19 and simultaneously maintain readiness for more common disasters such as hurricanes, earthquakes, floods, or wildfires. The agency became responsible for building “surge capacity” (ability to manage a high volume of patients), managing critical shortages of health supplies, distributing DHHS’ Strategic National Stockpile (SNS), overseeing the Supply Chain Stabilization Task Force and Project Airbridge which increased manufacturing and expedited shipping of consumer goods, and assumed authority for The Defense Production Act, Next-Generation SNS, and deployment of over 50,000 federal personnel.⁴

The Substance Abuse and Mental Health Services Administration (SAMHSA) is an agency within DHHS whose emergency planning role is to provide states, communities and responders with behavioral health resources that help them prepare, respond, and recover from disasters. SAMHSA has assisted in the response to COVID-19 by making available products and resources in various media that can be useful when coping with the effects of widespread public health crises for individuals, employers and populations at increased risk. They emphasized the immediate and potential long-term effects of the pandemic on the public and health care providers and responders and the importance for self-care and seeking help if needed. SAMHSA issued alerts providing guidance for many services such as opioid treatment programs, vaccine usage and continued to promote best practices for crisis counseling through their Disaster Behavioral Health relief efforts. Due to the pandemic and its associated economic stressors, SAMHSA has been assisting state behavioral health and Medicaid agencies with the financial challenges to meet both existing needs as well as an increase in demand, by issuing grants to address service demands and easing regulations to make telehealth more readily available. The Centers for Disease Control and Prevention’s (CDC) issued a report showing the immense and growing need for behavioral health services – four out of 10 individuals struggling with mental health and/or substance use and 11% having considered suicide.⁵ A blog published in *Health Affairs* aptly described the pandemic as the “perfect storm for psychological stress ... long-lasting storm will widen already massive mental health disparities among marginalized populations.”⁶

The Evolution of Disaster Behavioral Health

Disaster behavioral health is defined as the provision of mental health, substance abuse, and stress management services to disaster survivors and responders.⁷ Disaster Behavioral Health as a field was first established in the wake of the terrorist attacks on September 11, 2001, natural disasters, and other emergencies of the last several years. Research and studies have highlighted the close interplay between behavioral health and physical health and the importance of integrating them both into all

aspects of public health and medical disaster management.⁸ However, disaster behavioral health as we know it today became an integral part of emergency management when the Disaster Mental Health Subcommittee of the National Biodefense Science Board (NBSB). The Board was created by President George W. Bush in October 2007 through the Homeland Security Presidential Directive 21, paragraph 31 and was charged with submitting recommendations to the NBSB for protecting, preserving, and restoring individual and community mental health in catastrophic health event settings.⁹ In its report, the NBSB Subcommittee on Disaster Mental Health conceptualized “disaster mental and behavioral health” as including “the interconnected psychological, emotional, cognitive, developmental, and social influences on behavior and mental health and the impact of those factors on preparedness, response, and recovery from disasters or traumatic events.”¹⁰ The recommendations were presented to the NBSB in November 2008 and the NBSB sent its recommendations to the Secretary of DHHS describing the importance and context of the integration and provided details of the subcommittee’s assessment and recommendations regarding integration.

Residents and responders who experience a new disaster are at greater risk for adverse stress reactions. People may display symptoms and reactions such as:

- Emotional symptoms including as irritability or excessive sadness;
- cognitive dysfunction such as difficulty making decisions or following directions;
- physical symptoms such as headache, stomach pain, or difficulty breathing;
- behavioral reactions such as consuming more alcohol or interpersonal conflict; and
- failure to adhere to needed physical or psychiatric medication needs.⁸

Since that time, the need for behavioral health disaster capabilities has been demonstrated by research that has linked the exposure to trauma and the onset of other health care needs immediately following an emergency event.¹¹ For example, research suggests that after a traumatic event, individuals could later present with cardiovascular, musculoskeletal, and neurological illness, as well as psychiatric diagnoses such as post-traumatic stress disorder (PTSD), anxiety, depression, and substance use disorders, even years after the event occurred. There is also data demonstrating that costs associated with the treatment of these conditions also increase.¹²

It is now considered a best practice to integrate behavioral health into disaster EOPs and into elements of disaster response education and training and based on and advanced through research. However, in practice this integration is not be as robust across all jurisdictions. An important factor for integration is that it must be supported in underlying policies with clear lines of responsibility for implementing policy in practice.¹³ Just as emergency planners develop EOPs that incorporate a component for pandemics, they must also incorporate a behavioral health component.

SAMHSA has taken a comprehensive approach to providing guidance to states that simplifies the task of developing an emergency plan for disaster behavioral health. *TAP 34: Disaster Planning Handbook for Behavioral Health Service Programs* is SAMHSA’s most recent technical assistance publication, updated in 2021.¹⁴ It provides guidance for mental health and substance use disorder treatment programs wanting to develop or update a comprehensive, scalable, and flexible disaster plan. It addresses planning needs specific to programs that offer prevention services, outpatient or residential treatment, medically supervised withdrawal, and pharmacotherapy. In addition, SAMHSA developed a disaster kit to arm disaster recovery workers with materials that aid in responding effectively to the public during and after a disaster, and in dealing with any accompanying workplace stress. Other materials include supporting seniors, tips for healthcare professionals, trauma-informed care materials, and a disaster smart phone app. Finally, SAMHSA provides free disaster technical assistance, training, and consultation

efforts to help states, territories, tribes, and other disaster behavioral health providers plan for and respond effectively to mental health and substance use needs related to disaster events.¹⁵

COVID-19 Challenges for Behavioral Health and Future Directions

In conventional natural disasters, technological accidents, and intentional acts of mass destruction, a primary mental health concern is PTSD arising from exposure to trauma. Experiencing a pandemic was not contemplated to meet the current criteria for trauma required for a diagnosis of PTSD in the most formal sense, even though the experience of the pandemic can be considered traumatic in a general sense. However, one would expect other psychopathology, such as depressive and anxiety disorders, which have been fairly common sequelae.¹⁶ Unlike an acute traumatic stressor that has a discrete beginning and end, the COVID-19 pandemic is an ongoing event that has the potential to cause chronic stress. Chronic stress causes the body to stay in a constant state of alertness, despite being in no immediate danger. Prolonged chronic stress can disturb all major systems in the body (e.g., immune, digestive, cardiovascular, sleep) and can increase risk for psychiatric disorders and some physical disorders such as cardiovascular diseases and diabetes.¹⁷ Widespread trauma-informed care, which involves first recognizing that trauma is common among individuals, serves both in the immediate crisis and as a preventative measure against unforeseen future traumatic contexts.¹⁸

In its analysis of the current COVID-19 pandemic, UNICEF identified several potential negative consequences for children and adolescents, including the increased risk of child maltreatment and exposure to violence.¹⁹ The necessary public health strategies employed, including confinement and school closures, have underlined the hurdles of current protective systems to offer services to support vulnerable families and provide targeted and effective services to meet their needs. Leaders have already and will continue to make efforts to assist children and families by understanding what puts individuals at higher risk for traumatic stress, as well as adopting stress mediation strategies.²⁰ A trauma informed approach may never have been so important as during a pandemic to promote the health and well-being of all and to protect our marginalized populations at greatest risk.

Despite efforts that have been made in behavioral health emergency planning and integration into all hazards planning, many challenges remain in order to achieve the best possible responses. Additionally, many new lessons have emerged after the COVID-19 experience that can inform future disaster preparedness. These include the following:

- 1. Safety as a primary concern of providers.** Staff and client safety related to infection control were critical to the ability to provide behavioral health treatment. Initially, safety guidance for protocols, social distancing and COVID-19 testing was not widely available or accessible. Personal protective equipment shortages and shortages of cleaning and sanitizing products added to cases and exacerbated fear. Testing supplies and strategies took time to become widely available. A well-operating manufacturing and supply chain would prevent these shortages in the future.
- 2. Increased recognition of the significant psychological impacts of disasters.** According to a recent study, the prevalence of PTSD six years after a disaster was 11.3%, and the previous baseline prevalence was 4.2%, with onset mainly within 1 month and remission within 3 years

post-disaster.¹² During COVID-19 providers identified major problems with business operations, service provision, telehealth, client concerns, staff concerns, supplies, technology, illness/grief/loss, and communications.²¹ In addition, safety concerns surfaced related to child abuse, intimate partner violence, and substance abuse.²²

- 3. Need for integration of appropriate disaster behavioral health interventions and services into all phases of emergency management.** Some lessons learned from COVID-19 include the need for a cultural change for emergency planners from that of a medical response/public health response to one that fully appreciates and integrates behavioral health concepts. This includes responses to mitigate mental health impacts and incorporate planning for behavioral health populations. In short, acknowledging that behavioral health is part of public health.²³ However, this will need to be facilitated by national policy that establishes the joint roles and responsibilities between behavioral health and public health.

Engaging all facets of the community from political leaders, faith-based institutions and community members would assist in addressing local concerns.²⁴

- 4. Limited access to providers, medication and other evidence-based therapies.** Existing problems with lack of access to care were exacerbated by pandemic-created demand. Behavioral health professional workforce shortages and geographic imbalances in available care became increasingly problematic as case counts and fear continued to rise. Access to effective medication and other evidence-based therapies for individuals was difficult due to manufacturing and shipping delays. There is a Strategic National Stockpile of medications to be used in emergencies. During the annual reviews of SNS formulary policy recommendations, it has been strongly suggested that psychotropic medications be included in the SNS.²⁵ To provide necessary access, it should incorporate a full range of psychoactive and SUD medications. Behavioral health issues related to the pandemic will continue into the future for those with behavioral health conditions or those whose conditions emerge during the disaster. Therefore, sustainable behavioral health treatment and simplified referral pathways must be available and continue beyond the emergencies.
- 5. Telehealth and remote service provision.** Telehealth, which ultimately has included telephonic and video technology, was exceedingly helpful in solving many safety, access and workflow concerns. However, provider access was initially hampered by telehealth regulations. Access by clients was hampered by those who had limited access to technology and reliable internet services or had difficulty utilizing the technology. Utilization of the technology by staff without adequate training was also problematic. Other related problems that were reported included requirements for HIPAA compliant platforms and emergency exceptions to some of these restrictions and an inability to access electronic medical records. These created challenges to business operations and consumers initially, but regulation waivers and training eventually resolved these issues, and it quickly became invaluable. Actions taken now to unify regulations, simplify technology, expand internet access and provide training will serve us well in the future.
- 6. Challenges in anticipating and meeting needs of priority populations.** Early determinations of populations anticipated to sustain the greatest negative impact, i.e. priority populations, and

how to reach out to them could have had the potential to reduce negative outcomes. As COVID-19 was increasing in prevalence, it was becoming clear that congregate living facilities were being impacted quickly, such as nursing homes, some state psychiatric hospitals, jails and prisons and others. Other priority populations often include individuals with existing mental health, developmental disabilities, and substance use disorders, as well as health care workers,²⁶ first responders, marginalized populations, older adults and children, among others. Preparedness that includes planning across settings for these populations is needed.

- 7. Financial concerns of providers and consumers.** Financial relief for providers made available by various government agencies was helpful, but vehicles to make it available more quickly would also be beneficial. A survey conducted by The National Council for Mental Wellbeing reported that behavioral health providers on average lost 24.3% of revenue. Organizations with more diversified payment methodologies (e.g. Prospective Payment System) managed better financially.²⁷

Assistance with client loss of income that could have been used to pay for services also arrived slowly. The DHHS Office of the Inspector General's ability to reduce or waive beneficiary cost sharing for federal health care programs was impactful for Medicare and Medicaid beneficiaries.²⁸ However, some consumers faced unpaid insurance claims because their private or employer-based health insurance coverage violated the provisions of the Mental Health Parity and Addiction Equity Act (MHPAEA) by providing lesser coverage for behavioral health benefits than for physical health.²⁹ Parity compliance and enforcement programs should be supported and coordinated with state authorities as appropriate to avert this problem in the future.³⁰ Policy makers must take steps to improve access including the continuation of policies implemented during the pandemic, such as insurance coverage for telehealth, copayment waivers, and license reciprocity to enable telehealth across state lines.

- 8. Vaccines and hesitancy/refusal among persons with mental illness.** Many organizations have spoken out on behalf of individuals with mental illness to encourage vaccination prioritization. The British Medical Journal suggested that extra support would be needed as individuals living with mental health challenges have a historically low uptake of preventive health programs, such as the influenza vaccine.³¹ They expressed concerns that this population may simply get left behind because the nature of mental illness can stigmatize and impact sufferers' ability to speak and be heard. They suggest that prioritization is justified because within the larger population of those with serious mental illness there is considerable multimorbidity putting them at higher risk for COVID-19.³² During the pandemic, then American Psychiatric Association called on state public health authorities to include people with serious mental illness and substance use disorders in the high-risk priority categories with individuals over 65 years-old and those with high-risk medical conditions ages 16-64.³³ Solutions offered to improve vaccination rates are to embed vaccination clinics within mental health services, provide direct access to existing immunization registries which assists in both monitoring and coordination and/or to develop emergency legislation to allow for a wider group of health care professionals to administer the vaccinations.³⁴

State Behavioral Health System Leadership in Disaster Behavioral Health

Governors and their senior health and human services leadership play an essential role in incorporating a behavioral health strategy into the states' COVID-19 response and recovery approach. There are many key issues that are currently challenging state behavioral health systems. Some of these include challenges in maintaining access to treatment and services due to workforce shortages. Flow through systems is frequently impeded such as is seen with emergency department boarding, waitlists for admissions into state hospitals, waitlists for community placements and appointments for psychiatrists and other services. All of this is under the pressures of seemingly endless increasing demand for services. It will be critical to continue to advocate for flexibility of policies, program rules, and regulations, such as pursuing federal waivers for provider qualifications, telehealth coverage, prior authorization requirements, and where services can be delivered. Additionally, providing guidance, training, support, and resources (e.g., purchasing virtual meeting licenses and equipment) for behavioral health providers will be an ongoing need as the workforce shifts to flexibly modalities on a more long-term basis. Ongoing technical assistance for capacity building will be critical. There will be an ongoing need to continue to ensure that behavioral health system needs are among the priorities for federal funding and policy development. Many of the issues identified are still emerging and state and federal actions will require ongoing research to identify opportunities and follow up to determine outcomes.³⁵ To that end, it is critical for leadership within the behavioral health system to have a seat within policy conversations. COVID-19 has provided an increased opportunity for these partnerships to continue to forge a path forward.

Recommendations for the Post-COVID-19 future

1. Bolster the integration of disaster behavioral health into public health emergency preparedness and response.

The strength of a public health system rests on its capacity to effectively deliver the 10 Essential Public Health Services specifically laid out by the CDC and revised again in September 2020 to more specifically aim to address the needs to “protect and promote health of *all people in all communities,*” while removing structural barriers. The identified services include:

- 1) Assess and monitor factors related to public health
- 2) Investigate, diagnose and attend to population health problems
- 3) Communication to inform and educate
- 4) Strengthen, support and mobilize communities
- 5) Create, champion and implement policies, plans and laws
- 6) Utilize regulatory or legal actions to improve public health.
- 7) Enable equitable access to services
- 8) Enhance and sustain a diverse capable public health workforce
- 9) Improve functioning through evaluation and research
- 10) Build and maintain public health infrastructure.³⁶

The 10 Essential Public Health Services provide a framework for public health to protect and promote the health of all people in all communities. Behavioral health system leaders, along with

public health leaders, are increasingly recognizing that behavioral health is a subset of public health and as such behavioral health should assess which of the 10 Essential Public Health Services may need strengthening to best serve individuals with behavioral health needs.

2. Attend to health equity with specific efforts focused on the needs of high-risk populations.

SAMHSA defines behavioral health equity as the right to access quality health care for all populations, regardless of the individual's race, ethnicity, gender, socioeconomic status, sexual orientation, or geographical location.³⁷ This includes access to prevention, treatment, and recovery services for mental and substance use disorders. In March 2021, the CDC announced a plan to invest \$2.25 billion over two years to address COVID-19-related health disparities and advance health equity among populations that are at high-risk and underserved, including racial and ethnic minority groups and people living in rural areas. This funding represents CDC's largest investment to date to support health disparities in communities affected by COVID-19. Behavioral health services, both in-person and remote, are included in this funding as they are considered clinical care.³⁸ In addition to the CDC funding, the American Psychiatric Association (APA) has made specific recommendations advocating for more public health funding especially for vulnerable populations and eliminating racism in the justice system. In addition, the APA guidance called for education about intrinsic bias against persons with mental illness and minority populations, as well as reduced bureaucratic and logistical barriers to healthcare access including helplines, telehealth/Internet access, among others. served.³⁹ These tenets reflect important strategic direction to address the needs equitably for diverse populations.

3. Conduct mass psychological distress screenings and opportunities to provide emotional support.

In addition to providing medical care, already stretched health care providers have an important role in monitoring psychosocial needs and delivering psychosocial support to their patients, other health care providers, and the public. These activities should be integrated into general pandemic health and there should be widespread information sharing about emotional responses to disaster and supports available. Efforts by SAMHSA, through its Disaster Technical Assistance Center, in partnership with FEMA have helped infuse these types of resources and supports through a variety of grant mechanisms, including the Crisis Counseling Program grants.⁴⁰ These funding streams have provided tremendous opportunities for states to help support their communities through the emotional challenges with the pandemic. As these supports are available, following psychological distress screenings, support opportunities could be and have been offered at vaccine sites, in offices upon return to work and school and with special emphasis on high-risk groups, and as a sustainable model. This would create easy accessibility and maximize the number of individuals who could benefit. Providers conducting the screenings can offer suggestions for stress management and coping (such as structuring activities and maintaining routines), link patients to social and mental health services, and counsel patients to seek professional mental health assistance when needed.⁴¹

4. Continue to promote behavioral health surveillance and research.

Prioritization of behavioral health surveillance and research through monitoring and collection of quality longitudinal data will inform public health policies and disaster planning for the future. Although standard surveillance techniques such as daily and cumulative infections and deaths from

COVID-19 have been helpful, they provide a static view of what has already occurred. Trends in clinical outcomes will provide a look into how effectively care has been provided. Deaths by suicide, hospital admissions and readmissions, COVID-19 infections, improved symptom management, reduction in symptoms and critical incident reports, each yield data that can lead to ongoing policy and programmatic activity for improvement.⁴² The U.S. Census Bureau Pulse Household Survey had been conducted weekly or every two weeks and throughout the pandemic findings have been available on mental health symptoms, services and vaccination behaviors. It provides a point in time view but knowledge such as reasons for “not receiving the vaccine or not planning to” and “prevention actions among the vaccinated” are examples of data that would be helpful in planning as they explain thought processes and point us to barriers. Collection of varying levels of local and national data can help inform areas where mitigation measures may be most impactful.⁴³

Although most people with COVID-19 recover, another lesson learned leading to considered thought for the future relates to the “COVID long-haulers” experiences with COVID-19 Syndrome. This condition is associated with longer duration and lingering symptoms that look different from acute COVID-19 and can include persistent somatic symptoms including brain fog, fatigue, headaches, dizziness and shortness of breath, among others. Individuals with this syndrome can experience mental health symptoms such as anxiety, depression and PTSD. Ongoing surveillance and research will be needed to understand these types of long-term impacts.

5. Foster communications focused on behavioral health needs.

After action reports are generated by emergency managers following every emergency event to analyze how well an emergency was handled and to use feedback to improve future responses. These reports often reveal that roles, responsibilities and problematic communication can be common sources of confusion.⁴⁴ The efficacy of the response to COVID-19 has in part depended on the speed, scale and consistency of governmental intervention and communication, but also how communities have received, perceived, and acted on the information provided by governments and other agencies. The communication of information by government and receipt of information by the public has been complicated by the ever-changing nature of a pandemic, where new scientific information becomes available and the variability and trustworthiness of information sources. Government agencies must coordinate messaging to remove ambiguity.

Pandemic risk communication requires ongoing engagement with communities as effective communications and leadership are crucial to the management of pandemics and the rapidly changing societal and economic landscape. It takes transparency, civic engagement and development of trust in order to effectively communicate. Engaging in clear communication is essential to provide specific information on what to do and what to avoid, which can reduce anxiety and maintain order.

Leaders should also listen to the community’s needs and concerns. Communication should be adjusted to consider variations in health literacy and understanding of numbers across audiences, It is vital to recognize that communities may not be affected by a pandemic in the same way and to the same degree. For example, people with disabilities have specific and varied needs and others may have linguistic needs. Because the pandemic has also seen a surge in misinformation and confusing messages, transparently providing factual and current information prevents subsequent susceptibility to emerging misinformation and conspiracy theories.⁴⁵ At the same time as

information about public health issues is shared, there should be ongoing attention to communicating about resources to help alleviate anxiety, answer questions and point people to distress supports. This became evident with the increased volume of activity for the Disaster Distress Helpline when the pandemic was emerging.⁴⁶

6. Attend to the mental health of health care workers.

Health care workers including first responders were particularly vulnerable to emotional distress during the pandemic given their risk of exposure to the virus, concern about infecting and caring for their loved ones, initial shortages of personal protective equipment, longer work hours, and involvement in emotionally and ethically fraught resource-allocation decisions. Prevention efforts such as screening for mental health problems, psychoeducation, and psychosocial support should focus on health care workers and first responders at risk for adverse psychological outcomes. Previous research suggests that health care workers suffer from mental distress during and even years after previous epidemics.⁴⁷ Therefore, attending to the mental health of health care workers during epidemics should include universal screenings, early interventions, long term follow up, support groups, expansion of resources and employer programs that teach coping strategies.

7. Continue to build telehealth capacity.

Behavioral health professionals were thrust into telehealth as a matter of safety and necessity as the pandemic grew. Many embarked enthusiastically on this adventure but with little experience. A telehealth resource center in Minnesota cleverly developed “Telehealth in a Public Health Emergency: A Quick-Start Guide” with topics covering definitions, modalities, and basics of delivering psychotherapy and other specialty mental health services.⁴⁸ As telehealth will continue and expand, and with the knowledge and confidence that providers have obtained thus far, telehealth policy should be reformed. Utilization of telehealth necessitates a thorough review to identify obstacles (e.g. regulations, insurance) and opportunities (e.g. license reciprocity across state lines, expansion of coverage and amending beneficiary cost sharing).

8. Continue to foster training on aspects of disaster behavioral health.

Mitigation works best when behavioral health care training is consistent with critical importance of disaster behavioral health themes and efforts in the overall response. Standardized training based on core curricula will prepare a cadre of qualified, trained professional counselors and paraprofessional outreach workers to respond to the psychosocial needs of impacted individuals and communities.⁴⁹ The SAMHSA Disaster Technical Assistance Center, for example, created the Just in Time training to provide training about emotional responses and how to address them (<https://www.samhsa.gov/dtac/ccp-toolkit/just-time-web-based-training>). Since the populations with the greatest need for services are people of color and other marginalized populations, it is time to add cultural and linguistic needs to the training curricula. It will also open the door to a larger workforce with more relevant and improved skills to care for a population that has been underserved.

9. Maximize continuity and access to treatment for behavioral health populations.

The COVID-19 pandemic has complicated the continuous administration of individuals with behavioral health disorders with medication needs. This includes medication assisted treatment for

substance use disorders to individuals with opioid use disorders. and needed laboratory analyses for individuals on medications such as Clozapine or Lithium. Given the need for face to face visits for blood draws and other assessments, providing these medications became challenging. However, necessary flexibilities have been put in place by SAMHSA and other Federal entities to help ameliorate these challenges during this public health emergency. For medication assisted treatment, these actions include ongoing work with the Drug Enforcement Agency to ensure consensus around prescribing/dispensing opioid therapies, telehealth flexibilities, and mid-level practitioner clinical responsibilities.

10. Continue efforts to expand and develop a robust crisis care system.

COVID-19 has stretched the behavioral health crisis response system beyond what was ever imagined. Since it is anticipated that the pandemic will continue for some time, even in an attenuated state, a good preventive measure would be to improve the structure and capacity of our crisis services and crisis systems of care. This would include more and better linkages to the soon to emerge 988, re-routing of behavioral health calls from 911. A sea change is on the horizon with countless communities around the country working toward shifting crisis responders from police officers to behavioral health professionals, re-routing of individuals experiencing a crisis away from emergency departments to crisis stabilization centers, and improving community capacity to avert or lessen the number of crises through prevention efforts.⁵⁰ Whether in the context of COVID-19 or beyond, it is now clear that the role of crisis services must include operations to provide support in the context of a disaster. Planning these services with disaster behavioral health elements in mind will set the stage for much needed preparedness.

Conclusion

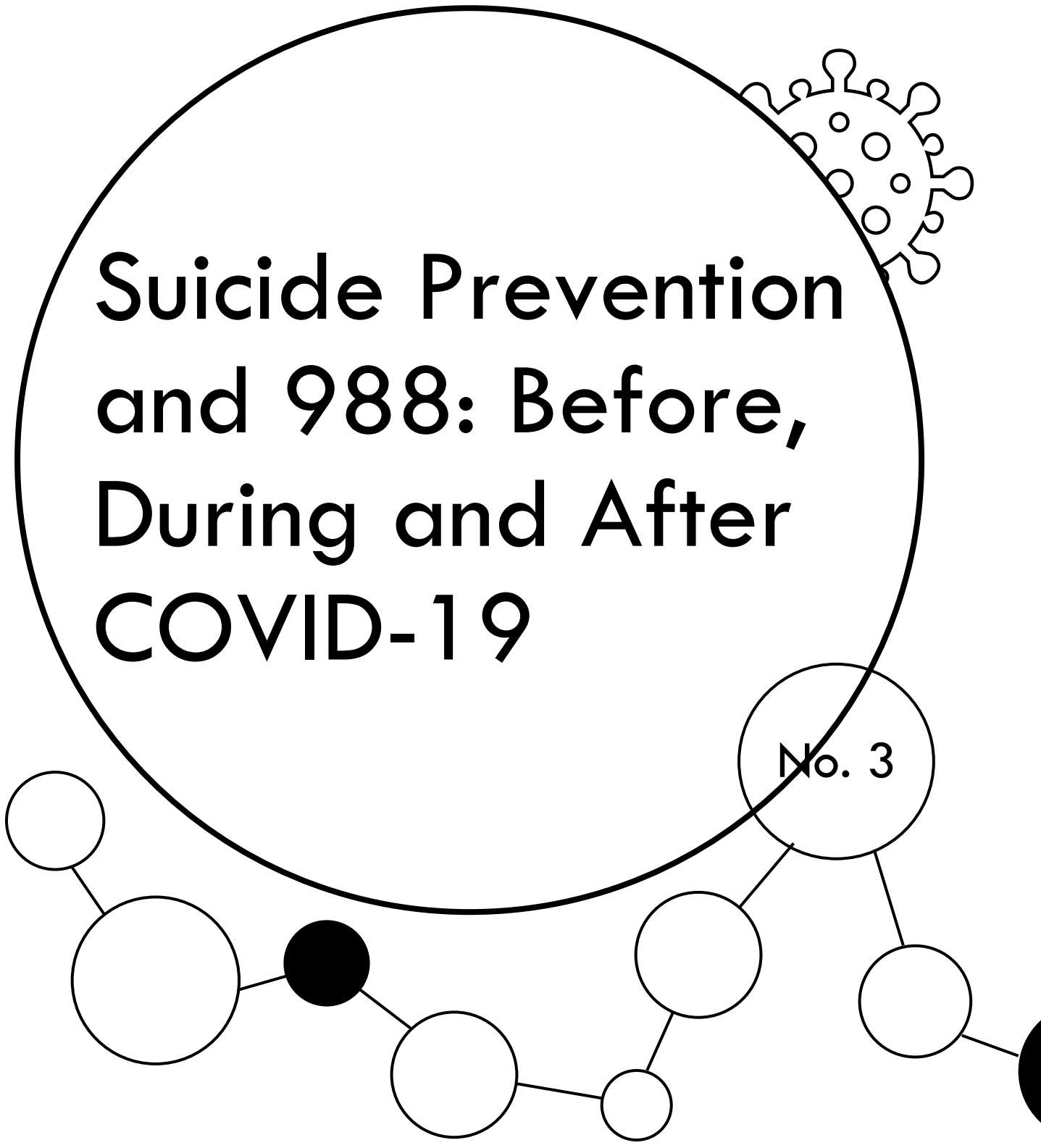
The spread of COVID-19 highlighted the importance of transforming behavioral health care. This unique virus presented a unique threat, and its aftermath will be just as unique and is still unfolding. The importance of immediate efforts focused on prevention and direct intervention continue to be needed to address the impact of the pandemic on individual and population level behavioral health. The pressing question is what have we really learned from this experience? Will we continue taking actions from lessons learned? Who is planning for the next pandemic so that our response is nimble, very well communicated, better coordinated and overall more effective? This paper in part aimed to document some of the lessons learned and potential avenues for future direction. We owe it to those we lost, to those who are currently ill or dying, and to those who could become victims of the next pandemic to take stock and keep improving in the field of disaster behavioral health.

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Suicide Prevention and 988: Before, During and After COVID-19

No. 3

NASMHPD

Ready to Respond:
Mental Health Beyond Crisis and COVID-19

September 2021

Suicide Prevention and 988: Beyond Beds Before, During and After COVID 19

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Third in the 2021 Ready to Respond Series of Ten Technical Assistance Briefs focused on Beyond Beds, Reimagining a Sustainable and Robust Continuum of Psychiatric Care



National Association of State Mental Health Program Directors

www.nasmhpd.org/content/tac-assessment-papers

September 2021

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Recommended Citation:

Gould, M. S., Lake, A. M. (2021). *Suicide Prevention and 988: Beyond Beds Before, During and After COVID-19*. Technical Assistance Collaborative Paper No. 3. Alexandria, VA: National Association of State Mental Health Program Directors.

This work was developed under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS283201200021I/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

Abstract:

Evaluations of crisis line networks in the U.S. have established the effectiveness of crisis line services as suicide prevention tools while also identifying the need for continued development of a robust and integrated crisis response system to meet the needs of individuals in suicidal and mental health crisis. These evaluation findings bolstered the rationale for the establishment of 988 as the new three-digit dialing code for the National Suicide Prevention Lifeline (Lifeline) beginning in July 2022. The upcoming transition to 988 will require expanded crisis center capacity and enhanced collaboration and communication across the crisis response system. The Lifeline responded to the COVID-19 pandemic by supporting crisis counselors' transition to remote work and remote supervision, and by providing online resources and information about stress management, COVID-19, and the expectable stages of psychological response to a disaster. An increase in calls to the Disaster Distress Helpline (a Lifeline subsidiary) was observed during the height of the pandemic, but an increase in Lifeline calls was not. Finally, testimony from Lifeline callers offers insight into their perceptions of their crisis call's effectiveness in preventing their suicide.

Highlights:

- Suicidal crisis callers report significant reductions in intent to die, hopelessness, and psychological pain over the course of their crisis call
- Crisis counselors are able to secure the caller's collaboration on an intervention on over 75% of imminent risk calls
- Emergency services are involved on 43% of imminent risk calls, and on 58% of third-party calls about a person at imminent risk
- When emergency services are involved, crisis centers often do not know the outcome of the intervention (i.e., whether the service was dispatched, whether the person-at-risk was located, or whether the person-at-risk was transported to a hospital)
- Users of crisis chat services are younger and more likely to report suicidal ideation than crisis callers

Recommendations for the Transition to 988:

1. Higher levels of funding will be needed to support the expansion of capacity at Lifeline call centers
2. In addition to crisis call centers, expanded access to mobile crisis teams and crisis stabilization facilities will be needed to support the diversion of callers from 911
3. Enhanced communication between crisis call centers and other crisis and emergency services will be needed to support continuity of care
4. Ongoing research should be supported to evaluate components of crisis services in order for systems to continue to be informed by evidence.

The National Suicide Hotline Designation Act of 2020 designates 988 as the national number for suicide prevention and mental health crisis response.¹ This has propelled crisis centers, specifically those within the National Suicide Prevention Lifeline (Lifeline) network, into the epicenter of plans for an improved mental health and suicide crisis response system in the U.S. When 988 becomes functional on July 16, 2022, the Lifeline will have an ever-increasing role in providing and coordinating crisis interventions in the U.S.

Suicide Prevention and 988 presents evidence on crisis lines as effective suicide prevention tools and discusses the challenges posed by COVID-19 and the upcoming implementation of 988. This includes:

- empirical evidence on the effectiveness of crisis lines in the U.S. that have helped establish them as a critical resource for individuals at risk for suicide
- an overview of current operations at the Lifeline, the Veterans Crisis Line (VCL), and the Disaster Distress Helpline (DDH), including responses to COVID-19
- the vision of 988 and the goal of a comprehensive behavioral health crisis response system
- challenges faced by crisis centers to meet the extra demands generated by 988
- examples of insights from Lifeline callers into the effectiveness of their crisis calls

Evaluations of U.S. Crisis Line Networks

National crisis lines were first highlighted in the 2012 *National Strategy for Suicide Prevention* and have continued their prominent position in the 2021 *Surgeon General's Call to Action to Implement the National Strategy for Suicide Prevention*.^{2,3} Yet, in 2001 when the first *National Strategy* was published, suicide crisis lines were noticeably absent. At that time, the evidence base for crisis lines' effectiveness was considered insufficient to include them in the National Strategy. The major milestone in the advance of crisis lines in the U.S. was the funding of a national network of local, certified call centers by the Substance Abuse and Mental Health Services Administration

(SAMHSA) in 2001. This network which since 2005 has been called the National Suicide Prevention Lifeline (Lifeline), serves as a central switchboard, connecting callers to a crisis center geographically nearest the caller from among a national network of more than 180 crisis centers in 50 states and the District of Columbia. The Lifeline added crisis chat services in 2013, and crisis text services in 2021. The Lifeline provides 24/7/365 free and confidential support directly to individuals in distress and to those calling, chatting, or texting out of concern for the well-being and safety of someone else. The Lifeline receives consultation and guidance from suicide prevention experts, consumer advocates and other stakeholders through the Lifeline's Steering, Lived Experience, and Standards, Training and Practices committees.¹ The evaluation of the national network has been ongoing since the network's inception in 2001. Results from the evaluations have been used by SAMHSA and the Lifeline to shape best practice standards across the network.

The National Suicide Prevention Lifeline can be reached by dialing 1-800-273-TALK (8255)

Starting on July 16, 2022, the Lifeline number will be replaced with a three-digit number, 988, with the goal of making the Lifeline more accessible.

The earliest evaluations of SAMHSA's crisis line initiatives examined proximal outcomes of crisis centers' effectiveness. One means to evaluate proximal outcomes involved silent monitoring of calls.^{4,5} Another

¹ More information on current Lifeline operations is provided in a separate section below.

means was through follow up assessments with callers to this network.^{6,7} For example, in one study, researchers monitored 2,611 calls to 14 crisis lines in the Hopeline Network (the precursor to the Lifeline), observing counselor behaviors, caller characteristics, and changes during the calls.^{8,9} The authors found that better call outcomes were associated with intervention styles that involved a supportive approach, good contact, and collaborative problem-solving – counselor behaviors that have been adopted as Lifeline standards. Other research studies assessed the outcomes of calls by employing callers' own ratings of their mental state and suicidality, in response to a standardized set of inquiries by the crisis counselors at the beginning and end of the call, to assess the immediate proximal effect of the crisis intervention.^{10,11} A follow-up assessment, two to four weeks later, was then conducted to assess the duration of the effect and the impact of the telephone intervention on future suicidal risk and behavior. The study of adult suicidal (n=1085) and non-suicidal crisis (n=1617) callers, sampled from eight crisis hotlines in the Hopeline network, demonstrated that seriously suicidal individuals were calling telephone crisis services (e.g., 8% in midst of an attempt, 58% had made a prior attempt); and that significant reductions in callers' self-reported crisis and suicide states occurred from the beginning to the end of the calls. Specifically, there were significant decreases in callers' reports of intent to die, hopelessness, and psychological pain over the course of the call.

In addition to the demonstration of crisis lines' effectiveness, early evaluations also identified a need for improvement in risk assessments, practices with imminent risk callers, and continuity of care for suicidal callers – areas foundational to a behavioral health crisis system. The evaluation findings in each of these areas are discussed below. Evaluations of the Lifeline Crisis Chat (LCC) intervention and those specifically focusing on the Veteran's Crisis Line will be discussed separately.

Risk Assessments

While providing support for the clinical effectiveness of the crisis lines, the results of the early evaluations also raised concerns about the adequacy of suicide risk assessments conducted by some crisis line staff.^{12,13} For example, researchers found that counselors did not consistently evaluate suicide risk and when evaluations were conducted they were usually incomplete.¹⁴ Furthermore, another study found that of the callers who were rated as non-suicidal crisis callers by crisis staff, 12% reported at the study's follow-up assessment that they had been feeling suicidal either during or since their calls to the center.¹⁵ Half of these callers reported being suicidal at the time of their crisis call, but this was not known or recognized by the counselor during their call.

In response, SAMHSA and the Lifeline focused attention on the standardization of crisis counselors' practices and training across the network.¹⁶ SAMHSA and the Lifeline began disseminating LivingWorks' Applied Suicide Intervention Skills Training (ASIST) across its network of centers.¹⁷ The evaluation of the impact of the implementation of ASIST across the Lifeline network utilized data from 1,507 monitored calls from 1,410 suicidal individuals to 17 Lifeline centers.¹⁸ Callers were significantly more likely to feel less depressed, less suicidal, less overwhelmed, and more hopeful by the end of calls handled by ASIST-trained counselors. Improvements in callers' outcomes were associated with ASIST-related counselor interventions, including exploring reasons for living and exploring informal support contacts. Despite these positive findings, most of the counselor interventions that were assessed did not differ between ASIST-trained counselors and non-ASIST-trained counselors. These findings may be explained by the considerable overlap in the content of the Lifeline centers' routine

LivingWorks' Applied Suicide Intervention Skills Training is an internationally disseminated gatekeeper training program designed as "suicide first aid."

trainings and the ASIST training, particularly with regard to risk assessments, as evidenced by the finding that both ASIST-trained and non-ASIST-trained counselors asked about or explored suicidal thoughts on over 90% of calls where callers acknowledged being suicidal. A more recent study involving the monitoring of 241 calls to ten California suicide prevention crisis lines also showed that most counselors asked about current suicidal ideation, but occurrence varied significantly across sites.¹⁹ Of note, they found that counselors at Lifeline centers were more likely to inquire about current suicidal ideation, recent ideation, and past attempts. Moreover, callers to centers that were part of the Lifeline network were more likely to experience reduced distress than callers to centers that were not part of the Lifeline.

Interventions with Imminent Risk Callers

The need for a clear and explicit policy for high-risk callers to the Lifeline was highlighted by the early evaluations of network crisis lines published in 2007.^{20,21,22} On monitored calls where a suicide attempt was in progress, one study found that emergency services were known to be dispatched in 18% of cases, and the caller changed his/her mind about the attempt in 24%, leaving 58% of calls without an observed mitigation of the caller's risk.²³ Another study found that emergency responses for callers deemed to be at imminent suicide risk varied considerably across eight crisis centers.²⁴ Overall, emergency rescue was initiated in 38% of cases in which callers had taken some action to kill themselves immediately before calling the centers.

In response to these shortcomings, the Lifeline published a Policy for Helping Callers at Imminent Risk of Suicide that provides guidance on making a judgment regarding imminent risk and outlines recommended practices for reducing imminent risk through crisis line interventions.²⁵ The Lifeline's Imminent Risk policy encourages counselors to actively seek collaboration with callers at imminent risk and to enable these callers "to work toward securing their own safety" ("active engagement");²⁶ the policy furthermore encourages counselors to use the least invasive interventions capable of preserving the caller's safety. Involuntary interventions ("active rescues") are to be used as a last resort because they may be unnecessarily stigmatizing and traumatizing and may deter future outreach for help.²⁷ Nevertheless, the Lifeline policy highlights the importance of initiating an active (i.e., involuntary) rescue when all other possible actions to prevent a caller from dying by suicide have been exhausted.

An evaluation of the assessment and management of imminent risk callers to the Lifeline employed data from 491 call reports completed by 132 counselors at eight crisis centers.²⁸ Findings demonstrated that crisis counselors obtained the collaboration of the vast majority (over 75%) of callers they identified as being at imminent risk, consistent with the Lifeline Imminent Risk policy. On 19% of imminent risk calls, the counselors sent emergency services (police, sheriff, EMS) with the collaboration of the callers, while on a quarter of the imminent risk calls, the counselors sent emergency services without the caller's collaboration. Overall, emergency services were involved on 43% of imminent risk calls. Other types of collaborative interventions implemented on imminent risk calls included getting rid of means (i.e., means that an individual might use to harm themselves), involving a third party, collaborating on a safety plan, and the caller's agreeing to receive follow-up from the crisis center. At least one collaborative, non-emergency intervention was implemented on 68% of all imminent risk calls, and on 37% of imminent risk calls where emergency services were involved.

The Lifeline is widely promoted as a resource not only for individuals in crisis but also for people who are concerned for the safety of someone in their social network. Given the reluctance of many suicidal individuals to seek help for themselves, working with individuals calling on behalf of someone else ("third-party callers") is as much a Lifeline priority as working with individuals calling on their own behalf

("direct callers"). It is believed that those who do not call on their own behalf may be at higher risk of suicide than those who do.²⁹ A recent study provided information on "third-party calls."³⁰ Reports on 172 third-party calls concerning individuals deemed to be at imminent suicide risk were completed by 30 crisis counselors at six Lifeline crisis centers. The study found that third-party callers were most likely to be calling about a family member or friend and were significantly more likely than the people about whom they were calling to be female and middle-aged or older. Counselors were able to collect information about suicide risk from the third parties, and counselors and third parties were nearly always able to identify at least one intervention to aid the person-at-risk.

Interventions identified were varied. Emergency services were contacted on 58% of the third-party imminent risk calls, which represents a somewhat higher rate of emergency services involvement than previously reported on imminent risk calls placed by the person-at-risk.³¹ The odds of emergency services involvement were higher if the third party was a high school student or young adult in contrast to middle-aged or older, if the third party was a friend or acquaintance of the person-at-risk in contrast to a family member, and if the third party's information was based on sources other than face-to-face contact with the person-at-risk. Odds of emergency services involvement were also higher if the person-at-risk was in the midst of an attempt or planned to act on suicidal thoughts within a few hours, or if these risk factors could not be ruled out. Counselor characteristics did not predict emergency services involvement. Non-emergency interventions, such as having the third party maintain a watch over the person-at-risk, or involving a mobile crisis team for evaluation or follow-up, were implemented on 69% of all calls, and on 47% of calls where an emergency intervention was also implemented. The study demonstrated that individuals calling the Lifeline when they are worried about someone are provided a range of interventions that can supplement, and at times replace, calling 911. Information about the outcome of emergency services dispatch was unavailable to the crisis counselors over half the time, indicating a need for improvements in information sharing across services.

Continuity of Care for Suicidal Callers

The early evaluation published in 2007 by Gould and colleagues highlighted the need for crisis centers to heighten outreach strategies to minimize suicide risk and enhance follow through with referrals.³² Follow-up assessments conducted two to four weeks after the crisis call found that a substantial proportion (42%) of callers continued to express suicidal ideation, 7.4% had made a suicide plan and nearly 3 percent had made a suicide attempt. Furthermore, only 23% of suicidal callers had been seen by the behavioral health care system to which they had been referred.

In response, SAMHSA funded an initiative in 2008 to have crisis center staff offer and provide follow-up calls to all Lifeline callers who reported suicidal ideation during or within 48 hours before making a call to the Lifeline. An evaluation of this follow-up initiative included 550 callers followed by 41 counselors at six crisis centers. Findings indicated that follow-up had a positive impact. In interviews with these follow-up clients, 80% indicated that the follow-up intervention stopped them from killing themselves and 91% reported that it kept them safe.³³ Clients were more likely to report perceived benefits of follow-up if they had higher baseline risk scores or if they had a previous suicide attempt.³⁴ Another evaluation demonstrated that a Lifeline crisis call can also play an important role in connecting at-risk callers to ongoing mental health care.³⁵ This study of 376 suicidal callers and 278 non-suicidal crisis callers showed that 52% of callers who received mental healthcare referrals ended up accessing care after their call. Thus, the Lifeline is enhancing the continuity of care for suicidal individuals, which is a priority of the U.S. National Strategy for Suicide Prevention.³⁶

New Media: Lifeline Crisis Chat

To increase access to crisis services, Lifeline’s service format has evolved to include not only telephone but also synchronous (i.e., in real time) chat crisis interventions. The Lifeline Crisis Chat (LCC) network, which serves all ages, has grown extensively since its formal establishment in 2013, answering 231,335 chats in 2020.³⁷ The availability of crisis interventions via chat is particularly critical for young people who are more likely to choose online rather than telephone crisis services,^{38,39} and who are also more likely to discuss “weighty problems,” such as mental health problems and suicide on an online crisis service than by telephone.^{40,41}

A study assessing the effectiveness of the LCC employed 13,130 linked pre- and post-chat surveys completed by recipients of Lifeline’s online crisis chat services in 2017-2018.⁴² Findings indicated that chatters were significantly and substantially less distressed at the end of the chat intervention than they were at the beginning. This is of particular import because the vast majority of individuals seeking help from the LCC were highly distressed when they contacted the service. Moreover, almost 84% of LCC chatters endorsed either current or recent suicidal ideation on the pre-chat survey, which is markedly higher than the estimated 23% of Lifeline callers who were identified by silent monitors as being suicidal on the day of or the day before their calls.⁴³ Findings were consistent with other research that also reported that crisis chatters reveal higher rates of suicidal ideation than crisis callers.^{44,45,46} By the end of the chat, two-thirds of suicidal chatters reported that the chat had been helpful and nearly half reported they were less suicidal, which offered some empirical evidence for the effectiveness of Lifeline’s online crisis chat services.

A second study analyzed pre-chat survey data and data abstracted from the transcripts of 1,034 Lifeline crisis chats in 2015 and found that chatters are younger on average than crisis callers and as noted previously are more likely than callers to disclose suicidal ideation at the time of the crisis intervention.⁴⁷ Lifeline chat counselors engage in rapport-building on nearly every chat with a suicidal visitor, and engage in problem-solving on over two thirds of such chats, demonstrating what seems to be a more balanced approach than has been observed in other evaluations of online counseling interventions.⁴⁸ However, counselors were not observed to assess suicide risk on all chats, and appeared to base their risk assessment activity to a significant degree on the visitor’s Pre-Chat Survey response. Information on current suicidal ideation was unavailable (i.e., current suicidal ideation was not discussed sufficiently to enable the coder to confirm it as present or absent) in the transcripts of a third of chats where the chatter had endorsed current suicidal thoughts on the pre-chat survey, over half of chats where the chatter had endorsed recent suicidal thoughts, and nearly three-quarters of chats where the chatter had denied suicidal thoughts on the pre-chat survey.

Veterans Crisis Line

The Veterans Health Administration (VHA) has set suicide prevention as a top priority given veterans’ increased risk of suicide compared to the general U.S. population.⁴⁹ To address this heightened suicide risk, in 2007, the Veterans Suicide Prevention Hotline (now called the Veteran’s Crisis Line (VCL)) was founded. Veterans, active-duty service members, and their families are connected to this line by calling the Lifeline number and pressing “1” when prompted. An online chat service was added in 2009, followed by a text-message service in 2011. Originally comprised of one call center, the VCL opened a second and third call center in 2016 and 2018. Since its creation, the VCL has received more than 5.4 million calls, 630,000 chats, and 204,000 texts.⁵⁰ Additional information about VCL is provided under Current Operations, below.

There have been few studies examining the effectiveness of the VCL. Employing VCL responders' evaluation of 646 calls from October 1 through 7, 2010 made by veterans who had endorsed current or recent suicidal ideation or a lifetime history of suicide attempt, the findings indicated that 84% of calls ended with a resolution, a referral to a local provider, or both.⁵¹ High-risk callers, as determined by responders' observations of intent to die and absence of future plans, had greater odds of ending the call with a referral (77%) compared to lower-risk callers (49%). A recent study interviewed 155 VCL users who were referred to a Veterans Affairs Medical Center Suicide Prevention Team.⁵² VCL users' responses to questions adapted from previous research indicated that 87 percent of interviewees expressed satisfaction with the intervention, nearly 82% reported that the VCL was helpful, and 72.9% said that the VCL helped keep them safe.⁵³ Nearly 83% of those with suicidal thoughts reported that the crisis contact helped stop them from killing themselves.

Overall, the empirical demonstration of the effectiveness of crisis lines in the U.S. for the past two decades helped to bolster arguments and lay a foundation for the new three-digit dialing code (988) for the national suicide prevention and mental crisis hotline system.

Current Operations and Response to COVID-19

The volume of calls, chats and texts received by centers in the National Suicide Prevention Lifeline Network in 2020 is presented in Table 1.

Table 1. Volume of Calls, Chats, and Texts Received in 2020

	Centers	Calls received	Chats received	Texts received
National Suicide Prevention Lifeline	Over 180 ⁱ	1,833,953 ⁱⁱ	586,703	34,166
Veterans Crisis Line (VCL)	3 ⁱⁱⁱ	679,549	80,053	35,489
Disaster Distress Helpline (DDH)	3 ^{iv}	60,188	n/a	11,444

ⁱ Over 30 of these centers handle chats and texts in addition to calls

ⁱⁱ This figure excludes calls to the VCL, which is reached by dialing the Lifeline number and then pressing '1'

ⁱⁱⁱ VCL calls are routed to three dedicated VCL centers

^{iv} DDH calls are received on dedicated lines at three Lifeline centers, with two centers also handling texts

Callers are routed to the center closest to the area code they are dialing from, with the goal being for calls to be handled locally by counselors who are familiar with local resources and culture. States vary in their ability to answer calls in-state, with the top third answering 82% or more and the bottom third answering 66% or less. Nine centers serve as national backup centers, handling calls that roll over when local centers have reached capacity. Individual Lifeline centers may maintain separate "warm lines" with their own telephone numbers, some of which are answered by individuals with lived experience of suicidal or mental health crises (also called peer-support lines); however the Lifeline does not administer a warm line or peer-support line at the national level. As Lifeline members, centers receive access to information, training, technology, networking, and a small annual stipend. Center operations are state- and locally funded. Centers range from stand-alone call centers to larger behavioral health organizations incorporating a call center along with one or more other services such as onsite outpatient treatment, crisis stabilization units, or mobile crisis teams. Lifeline centers may be non-profit, for profit, or governmental (e.g., county-run), and they may be staffed by licensed mental health clinicians, by other

paid employees, by volunteers, or by a combination of these. To standardize the crisis response provided across these diverse institutions, the Lifeline provides guidance regarding best practices in suicide prevention and crisis intervention through newsletters, webinars, and on its members-only Network Resource Center website (<https://networkresourcecenter.org/>). Crisis centers seeking to join the Lifeline network must be certified, accredited, or licensed by an external body, must have written policies or guidelines addressing counselor training, referrals, and suicide risk assessment, and must be willing to participate in Lifeline evaluation activities. Application is possible through the Lifeline website (<https://suicidepreventionlifeline.org/our-network/>). As described above, the Lifeline bases its policies and practices on ongoing evaluation research and on consultation with academic subject area experts and individuals with lived experience of suicide (see <https://suicidepreventionlifeline.org/lived-experience-committee/> and <https://www.activatinghope.com/>).

As noted above, although the Veterans Crisis Line (<https://www.veteranscrisisline.net/>) shares the Lifeline's national toll-free telephone number, callers who press '1' to reach the VCL are routed to one of three call centers specifically dedicated to veterans' care. Unlike many Lifeline call centers, VCL call centers do not utilize volunteers. VCL responders are clinicians trained in both crisis intervention and military culture, and may be Veterans themselves. They have the capacity to make referrals within the United States Department of Veterans' Affairs (VA) mental healthcare system,⁵⁴ and to link callers to a Suicide Prevention Coordinator at their local VA medical center, if needed and desired. The VCL thus provides a model of integrating crisis lines within larger health-care settings. The volume of calls, chats and texts received by VCL centers in 2020 is presented in Table 1.

The Disaster Distress Helpline (DDH, <https://www.samhsa.gov/find-help/disaster-distress-helpline> and <https://strengthafterdisaster.org/>) is a SAMHSA-funded national hotline dedicated to responding to distress caused by natural or human-caused disasters. DDH, a subsidiary of the Lifeline with a separate telephone number, was launched in 2012 and is accessible via telephone, text, or video phone for speakers of American Sign Language. DDH calls are routed to dedicated lines at three Lifeline call centers, with two centers also handling texts. DDH is now launching its first three Online Peer Support Communities, to be moderated by trained peer supporters with oversight by a Lifeline crisis center, accessible via Facebook Groups. These communities will be specifically targeted to healthcare workers impacted by COVID-19, parents and caregivers of children and youth impacted by COVID-19, and survivors of and responders to mass shootings in the U.S.

In response to the COVID-19 pandemic, SAMHSA increased its promotion of DDH, which saw a dramatic increase in calls, peaking in April 2020 at approximately 500% of pre-pandemic call volume, and stabilizing by August 2020 at approximately 250% of pre-pandemic call volume, a "new normal" which can still be considered part of the COVID-19 surge. The volume of DDH calls and texts received in 2020 is presented in Table 1. It should be noted that DDH call volume was relatively low prior to this surge, with centers receiving only 12,171 DDH calls and 1,543 DDH texts in 2019, roughly 1/5th and 1/7th the call and text volume in 2020, respectively. Unlike DDH, the Lifeline itself did not see an increase in calls during the height of COVID-19. This difference is likely to reflect both targeted efforts to promote DDH during this period, as well as the prevalence of DDH callers experiencing distress, but not suicidality, in response to the pandemic. Less than 1% of DDH callers and texters were identified by counselors as suicidal during their contacts with DDH.⁵⁵ Globally, no increase in suicide deaths has been observed since the onset of the pandemic,⁵⁶ however, an online survey of a nationally representative sample of US adults in late April 2020 found rates of moderate and serious mental distress elevated to three times their 2018 levels, portending possible increases in mental illness and suicide risk in future.⁵⁷ A survey of US adults conducted by the Centers for Disease Control in June 2020 demonstrated elevated levels of

suicidal ideation, particularly among young people, Black and Hispanic respondents, unpaid caregivers for adults, and essential workers.⁵⁸ Moreover, an examination of National Syndromic Surveillance Program (NSSP) data has identified an increase in emergency department visits for suspected suicide attempts among adolescents aged 12-17, especially girls, beginning in May 2020.⁵⁹ The more distal impact of COVID-19 on suicidal ideation and attempts, rates of completed suicide, and help-seeking by suicidal individuals is yet to be determined.

The Lifeline's response to COVID-19 to date has included offering the public information, coping tips, and digital resources accessible via the Lifeline website (<https://suicidepreventionlifeline.org/current-events/supporting-your-emotional-well-being-during-the-covid-19-outbreak/>). To facilitate engagement with Lifeline callers impacted by COVID-19, the director of the DDH offered Lifeline counselors guidance on the phases of reactions to disaster. Also for counselors, the Lifeline created a self-paced training entitled "Disaster Mental Health: COVID-19," housed on the Network Resource Center (NRC) and designed to familiarize Lifeline counselors with the types of mental health issues callers might be facing as a result of COVID. As many centers closed temporarily in early to mid-2020, the NRC offered guidance on the transition to remote work and remote supervision for crisis counselors.

988

In a 2019 Washington Post opinion piece titled "Let's dial 988 to stop suicides," Representatives Chris Stewart (R-Utah) and Seth Moulton (D-MA) described the National Suicide Hotline Improvement Act of 2018 as an effort to streamline access to the National Suicide Prevention Lifeline (Lifeline) for individuals in suicidal crisis by replacing its 10-digit telephone number (1-800-273-8255) with an easy-to-remember three-digit dialing code.⁶⁰ They referenced high rates of veteran suicide in particular as motivating their involvement in this legislation. In compliance with the directives of this Act, the FCC submitted to Congress a "Report on the National Suicide Hotline Improvement Act of 2018" based on reports from SAMHSA, the VA, and the NANC.⁶¹ Findings from the Lifeline evaluations were included in this report, and supported the FCC's conclusion that the Lifeline was an effective crisis intervention tool and that its reach and functioning could be improved by the implementation of a three-digit dialing code. The report recommended the use of 988 as the new number for "a national suicide prevention and mental health crisis hotline system... a 911 for the brain."⁶²

Following the FCC's recommendation that 988 be designated as the new Lifeline dialing code, Stewart and Moulton introduced to Congress the National Suicide Hotline Designation Act of 2020, in a further effort to improve Lifeline services by empowering states to collect fees to finance local crisis call centers in the Lifeline's national network. They envisioned this funding enabling Lifeline centers to improve response times and increase the percentage of Lifeline calls that are answered in-state rather than rolling over to a backup center. This legislation also created a legal basis to enable real-time communication between Lifeline crisis centers, 911/emergency dispatch, and hospitals. The legislation establishing 988 as the national number for suicidal and mental health crises thus takes concrete steps to streamline and support the connection of individuals in crisis to a Lifeline crisis counselor, while at the same time pointing in the direction of much more far-reaching reforms and toward the development of a comprehensive crisis response system.

When 988 is implemented, calls to 988 will be routed to Lifeline crisis centers, and callers will press '1' after dialing 988 to reach the VCL. DDH will continue to be reached via its current, ten-digit, toll-free number. With the increased visibility, promotion, and accessibility of 988, and given the intention

(discussed further below) of diverting substantial numbers of mental health-related calls away from 911, major increases in Lifeline call volume can be anticipated.

Comprehensive Behavioral Health Crisis System (Crisis Now model)

The National Action Alliance for Suicide Prevention's *Crisis Now: Transforming services is within our reach*⁶³ and SAMHSA's *National Guidelines for Behavioral Health Crisis Care: A Best Practice Toolkit*⁶⁴ present a vision of a robust and integrated behavioral health crisis response system able to achieve the following aims: to divert individuals in mental health crisis away from jails and emergency departments, to reduce unnecessary psychiatric hospitalizations, and to reduce law enforcement involvement in mental health crises. The urgency of the need for crisis response reform is reflected in recent reporting by *The Washington Post* that "about a quarter of all fatal police shootings in the last six years involved someone in the throes of a mental health crisis."⁶⁵ The Crisis Now model places crisis call centers at the hub of an integrated crisis care system, which also involves universal access to mobile crisis teams and crisis stabilization facilities. According to this model, crisis call centers would be responsible not only for fielding calls, de-escalating crises, and referring callers to additional services as needed, but also for tracking and coordinating individuals' use of these other services, in a role described as "care traffic control." This might involve the use of real-time dashboards showing the locations of mobile crisis teams, available respite beds, available outpatient appointments, and so forth, reflecting levels of available resources and of information sharing which many US communities can currently only dream of. Whereas some Lifeline call centers have integrated mobile crisis teams and crisis stabilization facilities, and others have relationships with other organizations offering these services, still others are located in communities where these services are lacking. One mechanism for ensuring these resources are available to Lifeline counselors for callers who need them is the establishment of Certified Community Behavioral Health Clinics (CCBHCs), which are mandated to include mobile crisis services and which utilize Medicaid funding to support such things as competitive wages for clinic staff and the purchase of technology to enable electronic information exchange.⁶⁶ As of this writing, 21 Lifeline centers have been certified as CCBHCs.

Conclusions and Next Steps Toward the Realization of 988

Evaluations of crisis hotlines in general and the National Suicide Prevention Lifeline specifically informed the push to designate a three-digit dialing code for mental health and suicidal crises in the US, and these evaluations will continue to inform the implementation of 988. Key points from these evaluations are:

- Individuals at risk of suicide do utilize suicide hotlines,
- Callers experience reductions in their crisis and suicidal states over the course of the crisis call,
- Crisis counselors can collaborate with callers to deescalate imminent suicide risk without the use of 911 or an emergency department,
- Callers may experience continued or recurring suicidal thoughts in the weeks following their crisis call, indicating a need for continuity of care,
- Follow-up calls are important suicide prevention tools,
- Crisis chat services are utilized by a young and high-risk population, and are important adjuncts to telephone hotlines, and
- Lifeline centers have been shown to be more effective than centers outside the network.

Key challenges to the implementation of 988 include:

- Dramatic increases in call volume can be anticipated, which will necessitate rapid increases in staffing and technological capacity at crisis centers;
- Crisis centers' ability to effectively resolve high risk mental health and suicidal crises without recourse to 911 will depend in part on improved access to mobile crisis teams and crisis stabilization facilities, services which are not now universally available;
- Coordination of care across the crisis response system will require enhanced communication between call centers, 911, EDs, and other crisis and emergency services;
- Given that 988 will be implemented on a state-by-state basis, some state-level infrastructure may be needed to ensure the availability and coordination of crisis response resources;⁶⁷
- Higher levels of funding will be needed to enable the expansion of call center capacity, reduce staff turnover, and facilitate the overall transformation of the US crisis response system.

Appendix: Insights from Lifeline Callers

Lifeline callers interviewed as part of an ongoing evaluation of the Lifeline who reported that the Lifeline call stopped them from killing themselves made the following comments in response to an open-ended question about what it was about the call that stopped them from killing themselves. These examples illustrate instances of crises being deescalated by the Lifeline call itself, and of high-risk callers being connected to additional resources without necessarily involving 911.

- *"I was at crisis point, I was very much considering killing myself and talking with the person got me from crisis to being very sad about the situation which is an emotion I can handle."*
- *"At first, I started off talking with complete honesty about how I had the knife to myself. At some point, the focus became less about the knife and more about what was going on in my life. It was very validating for me to be able to talk about the whole picture and vent for a bit. That really stopped me because I felt heard and understood. It felt very real and very raw. I got to talk about my life and the weight was lifted off my chest. The temptations went away after that."*
- *"She had me go and try to find the item that I was trying to end my life with and made sure I was comfortable throwing them away and helped me realize that I had a part that wanted me to live and helped me focus on that part and make it stronger."*
- *"I think it's bringing down the frantic energy because you get in this very volatile, emotional state where it feels like everything is happening so fast. You feel like you need to think and do everything so fast to keep up because you're panicking. I think that call slowed me down and made me realize I didn't have to make decisions in that moment."*
- *"She just kept talking to me and distracting me from that [killing myself]. She distracted me long enough until my brother was able to get there. They made sure my brother got there before they ended the call."*
- *"Without the call I would have never gone to the [community mental health] center. She helped me realize my breaking point and realize that I needed more help than I was getting. She helped me realize that I needed help."*

- *“I guess the way the person was talking to me and how they didn't assume things about me. They let me call somebody to come and pick me up and take me to the hospital. They let me choose to go to the hospital, but they also made me promise to go.”*
- *“I think that if I hadn't called anybody that night, I would've acted on my plan. I think it really saved my life that night. I had somebody to call and talk to, but it didn't involve cops and stuff. It was private and confidential.”*

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Law Enforcement and Crisis Services: Past Lessons for New Partnerships and the Future of 988

No. 4

NASMHPD

Ready to Respond:
Mental Health Beyond Crisis and COVID-19

September 2021

Law Enforcement and Crisis Services: Past Lessons for New Partnerships and the Future of 988

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Cover Art by Malkah Pinals

***Fourth in the 2021 Ready to Respond Series of Ten Technical Assistance Briefs
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National Association of State Mental Health Program Directors

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September 2021

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Recommended Citation:

Pinals, D. A., Edwards M. L. (2021). *Law Enforcement and Crisis Services: Past Lessons for New Partnerships and the Future of 988*. Technical Assistance Collaborative Paper No. 4. Alexandria, VA: National Association of State Mental Health Program Directors.

This work was developed under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS2832012000211/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

Abstract:

Lessons from history are essential to consider as policymakers reimagine a robust behavioral health crisis continuum that meets community needs. The role of law enforcement in crisis response has become fraught, with some advocates calling to defund police to prevent repetitions of tragic outcomes of police encounters, especially with Black and Brown men and individuals with mental illness. Yet, there are additional concerns that the elimination of law enforcement would have potential unintended consequences that could shift critical responses to ill-equipped mental health providers in high-risk situations. More and more, the dialogue has therefore moved to creating partnerships to enhance the community crisis response infrastructure. As 988 soon becomes operational, it is more important than ever to ensure that there is seamless connectivity between 911 and 988 for the proper response and responders for any situation. This may also reduce the use of law enforcement when not needed, while being mindful that situations will arise when risks might necessitate multiple responders on a scene. This paper aims to help shape future planning by highlighting current behavioral health crisis response services and current and historical emergency medical out-of-hospital response mechanics. It also reviews theories that help shed light on decades of racial inequities in police approaches to marginalized communities. Lastly, we offer considerations for high-risk situations to help policymakers consider some of the more challenging issues that may arise in crisis service development.

Highlights:

- Law enforcement, emergency medical services, and behavioral health will increasingly need to partner to plan and coordinate 988 and 911.
- The critical infrastructure of crisis services has become more apparent in the aftermath of COVID-19. Building adequate infrastructure will require more clarity in how communities may best execute responses.
- Mental health and law enforcement have a long and complex history of collaboration to help individuals get into treatment and keep communities safe, with important lessons to help improve outcomes in the future.

Recommendations for the post-COVID-19 future:

1. Efforts to leverage partnerships should continue across first responders of all types.
2. Training and cross-training is a critical component of maximizing the quality and dignity of crisis responses.
3. Trauma-informed crisis services should include an understanding of the traumatizing nature of being a first responder and stakeholders should make efforts to support law enforcement and other emergency personnel who serve their communities.
4. Enhancing the role of peer support specialists to work with law enforcement holds promise for achieving positive outcomes.
5. Training and policies must acknowledge and prepare for high-risk encounters in the crisis continuum.
6. Stakeholders can address racial disparities by taking stock of history and intentionally developing programs that focus on diversity and equity.
7. Empirical evidence should be pursued to help identify the effectiveness of specific partnership type behavioral health crisis response models.

There is a growing discussion advocating for reforming crisis responses in the wake of the recent killings of individuals with mental illness by law enforcement,¹ including Black men and women.² Policymakers, advocates, and scholars have called for interventions that decenter and even “defund” police,³ while promoting unarmed mental health or other clinicians to respond to individuals with mental illness or emotional disturbances when they are in crisis. Although some advocates consider such large-scale change in approaches to policing unrealistic, there is growing momentum to expand partnerships and the capacity of non-law enforcement clinicians from both the behavioral health system and the larger health system to respond and limit the role of law enforcement to those situations when possible. In some jurisdictions policymakers and legislators have weighed in on these partnerships. Take Connecticut for example, which passed a law enforcement “accountability” bill that puts more emphasis on oversight and review of police actions and has a section that mandates exploring the feasibility of partnering with social workers in certain responses.⁴ Even before the latest attention to these issues, mobile crisis services managed through local mental health authorities had been growing in number and availability across the United States. Parallel or integrated systems for youth mobile response and adult mobile response may exist in particular regions. Additionally, emergency medical responders may also be part of the community response to emotional crises.

Integration and coordination across behavioral health, emergency medical response, and law enforcement will be essential components for a robust crisis services system that calls for the right response and responders at the right time. These systems share a socially and politically complex past within the history of American society, with many aspects rooted in the history of American medicine. Appreciating the development of emergency medical services, community-oriented models of public services, and the role of law enforcement involvement in meeting the needs of individuals with mental health crises is essential to understanding the strengths and weaknesses of our current system and to informing improvement efforts as the promise of 988 becomes a reality.

There is an exciting dialogue happening across the United States related to the Crisis Now efforts.⁵ At the same time, history shows examples of both earlier successes of supporting disadvantaged communities to improve their health and well-being, but also the harmful effects of surveillance on marginalized communities at times in the guise of assistance. Taking stock of that history can augment future planning. This paper, *Law Enforcement and Crisis Services: Past Lessons for New Partnerships and the Future of 988*, as part of the NASMHPD 2021 technical assistance papers, aims to provide a historical background to community crisis responding between law enforcement and emergency medical personnel, to discuss broad structural issues that have contributed to racial inequities in the delivery of policing, and to review the current landscape regarding crisis response models in a world with the “Promise of 988” on the horizon. The Promise of 988 of the National Action Alliance and partner organizations brings the National Suicide Prevention Lifeline to a three-digit number but offers so much more in its goal of “crisis care for everyone, everywhere, every time.”⁶ Finally, this paper provides specific caveats and information regarding the management of high-risk situations where law enforcement will likely be involved, where tragedy can ensue if not considered carefully.

Early Models of Successful Community Engagement in Emergency Responding: Pittsburgh’s Freedom House Example

History provides examples of successful models of community engagement that enabled communities of color and others to reimagine health, safety, and well-being.

Freedom House emerged during the 1960s and 1970s spurred by persistent social inequality and the need for improved systems of emergency care. Pittsburgh's Freedom House Ambulance Service was a novel, socio-medical program that not only displaced police officers from emergency medical response roles in which they were not effective but simultaneously set national standards for emergency medical services.⁷ Before Freedom House, most pre-hospital emergency care was provided by police officers and morticians without medical training that utilized a model that emphasized transportation without medical treatment.⁸

President Lyndon B. Johnson's Great Society initiatives, and specifically the War on Poverty's Office of Economic Opportunity (OEO), supported programs "promoting public welfare, education, urban development and public health programs."⁹ As police performed a large proportion of pre-hospital transport, Black citizens relied on them for transportation to local hospitals for medical care. Because of the historical discrimination against Black citizens at the hands of police, having Black community members provide prehospital transport held promise for better outcomes. Ultimately, the OEO recruited Black men and women from low-income neighborhoods in Pittsburgh and partnered with physicians from the University of Pittsburgh Medical Center. A concerned group of Black and White citizens approached Peter Safar, MD, perhaps best known for developing the principles of cardiopulmonary resuscitation, for counsel on equipping vehicles for medical transport. Safar agreed to train Black community members to provide prehospital transport, and the Freedom House ambulance service thus partnered with Safar and the University of Pittsburgh Medical Center. Through this partnership, Safar and his colleague Nancy Caroline, MD, trained a group of Black citizens from marginalized communities in Pittsburgh to become paramedics and pioneer the training and delivery of emergency medical services.¹⁰

Freedom House proved enormously successful. It provided superior medical care compared to earlier models,^{11,12} and it advanced the development of a new cadre of emergency medical technicians as health care professionals.^{13,14,15} Freedom House improved the community morale for paramedics and Black and White citizens throughout Pittsburgh as a form of social enterprise. Despite these successes, however, racial discrimination and prejudice plagued the program. The program's reliance on local, state, and federal funding made it susceptible to local challenges from predominantly White suburban police and fire departments. And the city government sponsored the creation of a majority White "superambulance" service. Although the city administration cited Freedom House's cost as its rationale for deprioritizing the program, it simultaneously supported the more expensive "superambulance" program. As Edwards (2021) argues, with the shift to the "superambulance" program, the pre-hospital functions shifted to primarily white male professionals who came from neighborhoods outside their service areas.¹⁶ The history of Freedom House illustrates how community health programs can serve as better alternatives to policing and the ongoing dangers of racial inequities that can evolve in service delivery. As current crisis services expand, stakeholders cannot overlook the importance of the history of local citizens helping each other and of cultural competence in caring for community crisis needs.

The "Out-of-Hospital" or "Prehospital" Medical Response and growing "Out-of-Hospital" Behavioral Health Crisis Responses

The Freedom House initiative demonstrated the importance of delivering care early and where needed outside of hospital contexts. This approach is parallel to the idea of mobile crisis services that go to the scene of the behavioral health crisis to meet the needs of the individuals and avoid unnecessary hospitalization by taking steps to resolve the crisis in the most effective and least restrictive way possible. Whether providing emergency stabilization in trauma situations, administering life-saving

medications, or intubating on a scene, first responders employ a host of responses to care for individuals in crisis. Local medical authorities dictate protocols used in a particular region. And the on-scene responders— such as paramedics or emergency medical technicians—provide the local response under that medical authority. With the expanded partnerships with behavioral health, more interventions become possible.

Advances in behavioral health services are expanding this idea of behavioral health “out-of-hospital approaches.” For example, for youth mobile crisis services in many jurisdictions, the delivery of in-home supports and some post-crisis follow-up has advanced the continuum of crisis care delivery in behavioral health. Massachusetts, spurred in part by the Rosie D litigation,¹⁷ and Connecticut with its youth Mobile Crisis Intervention Services,¹⁸ are leading examples of such in-home and “out-of-hospital” interventions.

The CAHOOTS model (Crisis Assistance Helping Out on the Streets)¹⁹ has also received national attention as the conversation about non-law enforcement responses has become louder. This program runs out of Eugene and Springfield, Oregon, and was designed and implemented in the late 1980s as an alternative to community police intervention to help persons in a mental health crisis, with substance use disorders or facing homelessness. Two-person teams—often a nurse and a paramedic type responder trained to deal with behavioral health crises—are sent to the scene of the crisis, where they provide trauma-informed responses to attempt to resolve the situation. They only rarely must call the police.

New tools, technologies, and treatments, from telehealth to naloxone²⁰ and buprenorphine induction²¹ for opioid use disorder, dramatically reconfigure the types of care and aid individuals can receive outside hospital settings. Perhaps nowhere is the capacity for the democratization of health care and the expansion of access to life-saving treatments in mental health and substance use crisis response more evident than in naloxone administration and efforts to help individuals with opioid use disorders be linked to treatment from the emergency response. This opportunity has been aided in part by Good Samaritan laws, which aim to reduce barriers to seeking emergency care. With the rise in opioid deaths nationally, most states adopted some form of these Good Samaritan laws to all individuals aware of someone’s opioid overdose to call for emergency assistance without fear of prosecution. The application of life-saving technologies, aided in part by progressive laws meant to decriminalize substance use, in some ways highlight a tension between the medical goals of emergency response and treatment and the public safety goals of deterrence. These approaches, however, also further exemplify the promise of a mobile response to a behavioral health crisis that can deliver immediate access to care—and eliminate the necessity of a justice system response with the help of policies that align these practices.

Current and Emerging approaches to Crisis Calls: Taking Stock of 9-1-1 in Envisioning 9-8-8

The task of aligning response systems highlights the organizational structures, interconnections and jurisdictional variations between crisis services for individuals receiving public mental health supports, emergency medical services, and law enforcement responses. These differences may be more apparent when systems respond to catastrophic disasters²² or community behavioral crises. Across emergency services as they exist today, all jurisdictions have identified “Public Safety Answering Points” or PSAPs, which serve as a central hub where 911 calls are routed directly from the control center in each state. There are primary PSAPs that get direct calls and secondary PSAPs to which calls are further routed. A PSAP registry was started in 2003 by the FCC in December 2003 to gather data regarding the readiness of the 911 system to respond to needs.²³ When 911 is dialed, there is a triage decision in which the caller is generally asked what type of emergency is taking place, with a determination made at that level

as to whether to dispatch an EMS response, fire department, or law enforcement. For example, in the city of Rochester, when someone calls 911, a telecommunicator is considered the first link in what can be referred to as a medical survival chain.²⁴ The telecommunicator is trained to ask questions and provide instructions to the caller, including talking the caller through situations ranging from CPR to childbirth while the caller waits for the proper assistance to arrive on the scene. The telecommunicator dispatches a responder to the scene using computerized systems.

As it has become clear that mental health situations require their own most appropriate, least restrictive available responses, some communities have been examining this triage process and determining how best to forge partnerships so that the law enforcement response is shifted from the default response to one that is there when needed. As such, some jurisdictions have opted to add a fourth option to the 911 call to determine if there is a mental health emergency. For example, the city of Austin in February 2021, implemented that fourth option for dispatch to ask emergency callers if their call was related to a need for mental health services.²⁵ Moreover, many communities have developed mental health crisis access lines, which people (especially in the public behavioral health system) are given to call in case of a crisis. These behavioral health crisis lines may mobilize an alternative response of a mobile crisis intervention team of various designs that also intersect with police responses (Figure 1).

As noted in *Crisis Services: Meeting Needs, Saving Lives*²⁶, this growing development of mobile crisis responses across communities and partnerships with law enforcement is not a new area. In the last 20 years, one of the impetuses

for this growth has been the national dialogue related to the Sequential Intercept Model, which added Intercept 0 as part of its framework²⁷ to help communities specifically target the development of community crisis responses both as part of jail diversion and law enforcement deflection efforts. Studies have shown positive results related to jail diversion and reducing the likelihood of individuals with mental illness being routed to jail. These may include specialized responses such as those that involve a police-friendly crisis drop off point or police referral of an individual to a mental health specialist.²⁸ Primers are

Figure 1. Basic Designs of Law Enforcement and Mental Health Partnerships (see also [Crisis Services: Meeting Needs, Saving Lives](#))

<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 for calls where a behavioral health specialist might be helpful.
<i>Mental health-based mental health response</i>	Services also known as mobile crisis services, where a mental health unit, staff person or team of staff respond directly at the scene of the crisis; Law enforcement may or may not jointly and cooperatively appear on the scene.
<i>Blended and Innovative</i>	Services that involve unarmed officers, peer support collaborations, community response teams that utilize a combination of efforts to enhance options for responding.

available to illustrate examples of how these relationships between police and mental health systems have been operationalized and enacted around the country over several years.^{29,30 31} Many communities show tremendous growth in this area of mobile crisis response, and SAMHSA's *National*

*Guidelines for Behavioral Health Crisis Care Best Practice Toolkit*³² calls for ongoing efforts as part of advancing a crisis services continuum. Thus, in many communities, mobile crisis supports and stabilization services are becoming well-recognized and widespread.

The Vera Institute describes the police and community responders arranged on a continuum, with either a police-only response, a combined type of response, or a community-based non-law enforcement response to the crisis.³³ These conceptualizations of a continuum present an interesting premise and one that can help a community conceptualize an infrastructure they are hoping to build. In a recent *Open Minds* executive briefing on “Building New Bridges,” author Monica Oss described several examples of innovative and hybrid approaches to behavioral health and law enforcement emerging across the country.³⁴

Because persons with disabilities warrant support rather than criminalization for the manifestations of their conditions, and the Americans with Disabilities Act and *Olmstead v. L.C.*³⁵ respectively dictate attention to meeting the needs of individuals with disabilities and access to care in the least restrictive community-based alternatives appropriate to their needs, it is more critical than ever to ensure the most robust behavioral health response possible in communities around the country while intentionally planning how stakeholders might best construct a response and what roles each of the responders might play. To that end, there may be several aspects of the work that can help improve outcomes as partnerships are formed discussed below. Before one can get to these areas, however, it is important to review critical areas related to race and equity and high-risk encounters that crisis services will need the tools to tackle at this interface.

Mental Illness, Surveillance, and Policing in History and Addressing Race/Equity Challenges

When considering moving toward community-based interventions that may limit the role of the police, stakeholders can glean helpful lessons by understanding how historical efforts to address public safety needs have furthered structural inequities across communities. As historian Nic John Ramos writes in his history of racial liberalism in policing in California, many scholars and advocates viewed the community mental health movement as a “benevolent movement,” one that simultaneously paved the way for “new surveillance and policing strategies” such as broken windows theory.³⁶ This theory of policing conferred a necessity to address even minor crimes such as vandalism to prevent a more serious crime. The broken windows theory was popularized in New York City during the 1970s and 1980s and it resulted in heavier policing in disadvantaged communities. On the other coast, psychiatrists at the University of California at Los Angeles similarly developed racially liberal approaches to policing. These approaches considered Black and White communities similar to each other regardless of what was happening in their respective communities. Despite these ostensibly progressive ideologies, scrutiny and surveillance for people of color continued to increase across the country, resulting in more “forms of incarceration, segregation and discrimination.”³⁷ In arguing for racial sameness, these approaches showed the pitfalls of racial liberalism by enabling – and intentionally deprioritizing – the social structures and systems that reproduced poverty, health and socio-economic inequity in Black communities.

Partially in response to some of the civil unrest of the late 1960s, as Ramos argues, psychiatrists and social scientists pursued a unified agenda to “align anti-poverty policies with the community mental health movement and the movement for psychiatric deinstitutionalization.”³⁸

As large urban centers increased aggressive policing and surveillance efforts in underserved neighborhoods, however, the net effect of this change was that “rioting, crime, drug use, domestic abuse, and family dysfunction” were seen more as “race problems”³⁹ than consequences of structural racism and discrimination.⁴⁰ To this day, these critical infrastructure conceptualizations create disparate education, housing, employment, and mental health outcomes. As crisis services evolve to provide more just and equitable care for all who need it, these forms of structural problems will continue to create parallel systems if not attended to in a more intentional way moving forward.

Contemporary discourses on crisis services, law enforcement, and the potentials of the 988 federal mandate must consider issues of race, structural racism, justice, diversity, equity, and inclusion. Such a consideration highlights the importance of partnerships, policies and protocols. To be sure, there have been general disparities in police activity across multiple axes of difference, including race, gender, and mental health status. Individuals with a mental illness involved in police interactions are 16 times more likely to die during such interactions than individuals without mental illness.^{41,42} Even more devastating, Black people with mental illness are 2.8 times more likely to die than their White counterparts.^{43,44}

Structural racism explains not only why racially and ethnically oppressed groups have poorer health access, opportunities, and outcomes than their White counterparts,⁴⁵ but also explains how racialized violence by police and others lead to lower rates of sanctions, penalties, and criminalization for law enforcement officer-related deaths.⁴⁶ Racialized legal status, the legal classifications such as criminalization and immigration status that have a disproportionate effect on minority persons further reduce access to care, determine health outcomes, and shape the legal circumstances and life trajectories that many individuals with mental illness navigate each day.^{47,48}

Social inequality is behind much of these disparities, shaped by a longstanding history of structural racism. White Americans, for example, have a net worth nearly 10 times greater than their Black American counterparts.⁴⁹ Historical practices of structural racism have reduced financial, residential, and occupational opportunities for minoritized persons in the United States. Exclusion from social and safety net programs,⁵⁰ neoliberal contractions of social programs during the 1970s and 1980s,⁵¹ residential segregation driven partly by the Federal Housing Administration,^{52,53} and other forms of racial discrimination have contributed to the disparities in wealth accumulation in the United States.⁵⁴ Residential segregation, a social determinant of health that impacts downstream factors including neighborhood quality and safety, access to food and resources, education,⁵⁵ and the climate of police officer interactions, has been one of the strongest drivers of health inequities among African American populations.

People who are racially and ethnically oppressed have higher rates of chronic disease; experience earlier onset and increased severity of disease; are less likely to have access to medical care; receive poorer quality medical care than their White counterparts, are more likely to die prematurely from disease, and experience racism as a psychosocial stressor.⁵⁶ The fact that nearly one-third, one-fifth, and one-fourth of Black, Latinx, and indigenous peoples, respectively, report not seeking medical care due to experiences of discrimination⁵⁷ also raises concerns about associations between race, policing, and mental health. Consider a recent study that found that police killings of unarmed Black Americans have “spillover effects” by increasing the number of poor mental health days. Black Americans who have faced discrimination in medical care may be less likely to seek care and are at greater risk of the deleterious mental health effects of police killings of unarmed Black Americans.⁵⁸

Disparities in mental health care go beyond experiences of interpersonal racism, extending into mental health care outcomes, policies, tools, and diagnostics.⁵⁹ The overdiagnosis of schizophrenia among African American populations is well-documented.⁶⁰ Research suggests that African Americans and other minority groups are more likely to present with different illness scripts, which likely increases the rate of misdiagnosis of schizophrenia.⁶¹ Moreover, mental health clinicians are less likely to elicit affective symptoms when evaluating patients, leading to twice the rate of misdiagnosis.^{62,63} Even when particular symptom pools are observed (i.e., psychosis), clinicians may over-value positive and negative symptoms in affective psychosis,^{64,65,66,67,68} leading to beliefs that mental illness among Black populations is more chronic and persistent.⁶⁹ The perception of more severe mental disease leads to higher prescribed doses of antipsychotic medication and higher rates of medication-related adverse effects such as tardive dyskinesia.^{70,71,72,73} Therefore, it is not surprising that non-White patients have a greater incidence of restraints despite no difference in violence risk, and are more likely to be placed in restraints or seclusion when admitted to psychiatric emergency services.^{74,75}

Racial and mental health inequities help drive the penetration of African Americans and other racially and ethnically oppressed groups deeper into the forensic and criminal justice systems. Mental illness generally, and drug use and addiction in particular, are criminalized in the United States.⁷⁶ This increased criminalization is more prevalent in communities of color vis-à-vis the compounding effects of structural racism and residential segregation. Consider the “two-tiered system” of substance use disorder treatment in the United States.⁷⁷ Whereas office-based buprenorphine maintenance by monthly prescriptions is more heavily concentrated in higher-income predominantly White areas, DEA-regulated methadone clinics require daily observed dosing and is heavily concentrated in Black, Latinx, and low-income neighborhoods. Such disparities are enabled by the very logic of policymakers and advocates for mental health policy: In supporting the Drug Addiction and Treatment Act of 1999, one scientist testified that “[methadone]... tends to be concentrated in urban areas, [and] is a poor fit for the suburban spread of narcotic addiction.”⁷⁸

The history of mental health treatment in the United States helps explain the role that policing plays in considering how intersecting identities of being Black and having a mental illness shape outcomes for individuals. The deinstitutionalization of the 1970s that increased transitions of men and women from state psychiatric hospitals coincided temporally with the popularization of “tough-on-crime policing [that] began to drive up incarceration rates,”⁷⁹ though, the relationship between these policies is more complicated than one might read in popular media. Nevertheless, for many different reasons, police have become increasingly more likely to engage with persons with mental illness as first-responders.⁸⁰ Often referred to as “quasi-mental health professionals...street corner psychiatrists... and frontline mental health workers,” police officers have become an indispensable link in the community mental health system.⁸¹ It has been postulated that police would continue to serve in this role as long as the mental health system remained fragmented.⁸² Police frequently arrest homeless persons and individuals discharged from psychiatric treatment facilities, and most officers report responding to mental health crises on a weekly to monthly basis.⁸³ Yet, police continually note a lack of adequate mental health training despite this vital function of their role.

Addressing longstanding and pervasive forms of structural violence and institutional racism will require active antiracist policies and programs that center the experiences and perspectives of marginalized populations.^{84,85} This includes an intentional focus on how stigma and mental illness further these disparities. Policies and practices should involve these communities as agents as was seen in the Freedom House initiative.⁸⁶ There must be sufficient workforce diversity to ensure the healthcare system meets the needs of the communities it serves, such as a workforce that challenges the use of

race-neutral and racially liberal perspectives in diagnosis, treatment, policing, and research that fail to address the persistence of structural racism.^{87,88}

High-risk Situations

Fragmentation across responders arriving on the scene of a crisis can contribute to chaos on the scene. There may be a deployment of any number of people and professional types that arrive at a scene including blue uniforms, white coats, and plain-clothed community responders. When law enforcement, emergency medical response, and mental health work together for situation resolution, even in high-risk situations, positive outcomes can be seen. For example, during the pandemic in Washtenaw County, Michigan, an armed man was reported to be having mental health challenges. The embedded community mental health clinicians and other responders assisted a local emergency law enforcement SWAT team in bringing all parties to safety after a 36-hour standoff.⁸⁹ The heroic and coordinated response included leadership, patience and strategic planning.

Yet, first responders coming to a mental health crisis often come from siloed places and may be disconnected from each other, making such positive outcomes less likely. There are many lessons that can be learned from high-risk encounters between law enforcement and people with mental illness including those that have resulted in fatal shootings.⁹⁰ At best, if well-coordinated and thoughtfully executed, there can be a calming effect on the situation. At worst, a situation can escalate with potentially avoidable dire consequences in the heat of the moment.

Most police officers will encounter an individual with mental illness, with estimates that one in ten police encounters involve someone with a mental illness.⁹¹ Yet, even with crisis services expanding, many police departments still lack a specialized system to handle issues specifically related to mental health situations. However, without specialized training, policies, or coordinated responses, police may not adequately adjust their techniques to appropriately address individuals' special behavioral considerations and capacities in mental health crises.⁹² Moreover, individuals with mental illness may not respond effectively to police commands, which may lead police to justify the escalation of force.⁹³ Training typically focuses on awareness of mental illness, verbal skills, and crisis intervention and de-escalation strategies. Still, there are numerous challenges in the field, including working with psychiatric hospitalization involuntary commitment laws⁹⁴ and navigating complex and high-risk situations. Despite advances in many areas, it is important to recognize situations that can arise that are too dangerous for anyone else. Preparation and acknowledgment that these situations can arise in communities are critical.

One example of a high-risk situation includes “suicide by cop” in addition to firearms or other serious weapon-related threats. “Suicide by cop” may also be referred to as “victim-precipitated homicide,” “law enforcement forced-assisted suicide,” and “law enforcement officer-assisted suicide.”⁹⁵ This phenomenon occurs when a suicidal individual provokes deadly force from a law enforcement officer who is then compelled to act in self-defense or to protect public safety. Police officers may not be aware of their instrumental role in assisting an individual’s suicide at the time of an incident. One study found that psychiatric and medical illness and substance use accounted for 56% of victim-precipitated homicide involving police.⁹⁶ Low socioeconomic background, criminal history, prior suicide attempts, and many other factors are strongly associated with these incidents.⁹⁷

Dewey and colleagues parsed suicide-by-cop cases into three subtypes: those involving mental illness, criminality, and those that were not otherwise specified. Each subtype showed differences in the levels

of substance use, symptoms of mental illness, or involvement of criminal behavior.⁹⁸ The study further found that decreasing fragmentation between mental health and law enforcement might be one way to help with prevention.

In situations where police tragically shoot an individual, subsequent psychological autopsies may reveal more details about the police actions and the victim's intent leading up to the incident. As emotional and political as it may be, it is critical to review and learn from high-risk encounters in "after-action reviews." Litigation in this area is common, with one San Francisco case recently heard by the U.S. Supreme Court examining aspects of the Americans with Disabilities Act (ADA) concerning a police encounter with an individual with mental illness.⁹⁹ Ultimately, the U.S. Supreme Court did not settle a dispute among the circuit courts regarding whether individuals could pursue a lawsuit under the ADA for an arrest that failed to provide accommodations for persons with disabilities. In the aftermath of the Court's review, however, one author suggested a "sliding scale" of accommodations that increase as threats are diminished and a scene is more secured.¹⁰⁰ This model presents an interesting way to consider reviewing incidents and training prospectively. By reviewing both positive and poor outcomes, crisis responders may improve the quality of responses and improve understanding of the role of mediation skills, emotional regulation, verbal de-escalation, and educating police about mental illness to reduce stigma.¹⁰¹

Another example of high-risk situations includes hostage and barricade situations, which may also benefit from partnerships with mental health professionals. These partnerships already span decades, with one study dating back to 1993 showing that 39% of surveyed law enforcement hostage negotiation teams worked with mental health professionals and found improved results when doing so.¹⁰² In these settings, psychiatrists, psychologists, social workers, and other mental health clinicians may help assist in crisis negotiation, which typically involves verbal de-escalation to reduce emotional tension and acuity aimed at safe resolution of these situations. Psychiatrists and other mental health professionals consulting in crisis negotiations often serve in advisory capacities rather than negotiators.¹⁰³ They may also participate in training, assessments, and debriefings.¹⁰⁴ When mental health professionals are brought into these roles, it is important for them to receive training and to continue to practice within their ethical frames and avoid taking on quasi-law enforcement roles. They may therefore benefit from consultation before embarking on these roles and as their work unfolds. Nonetheless, strengthening the crisis care continuum involves considering situations that can present high-risk scenarios where law enforcement will be instrumental in helping safety be realized.

Bringing Lessons Forward: Importance of partnerships, policies, peers, and trauma-informed practices

One of the most recognized law enforcement approaches to mental health crises involves the Crisis Intervention Team (CIT) model. Although originally seen more as a police-based specialized police response model, CIT International's evolving protocols look to improve systems across multiple dimensions, including:

- increasing safety,
- increasing connections to mental health services for those who need them,
- only using law enforcement "strategically" in higher-risk or criminal encounters,
- increasing the roles of mental health professionals and peers,
- reducing trauma for individuals in crisis to help support their recovery.¹⁰⁵

CIT International recently issued its own “Best Practice Guide” to help foster communities attempting to meet these goals.¹⁰⁶ Although formal CIT may not be suitable for every department and new models are emerging recognizing that CIT has its advantages and limits, there are many lessons that CIT can teach about building specialized services and establishing partnerships and community problem-solving. Furthermore, stakeholders, policymakers, and behavioral health specialists need more data about the effectiveness of CIT in reducing use-of-force outcomes.¹⁰⁷

Policies for emerging 988 response models will also need to be developed and can leverage lessons learned from CIT and other practices. Medical control authorities have very rigorous protocols for what types of interventions might warrant particular responses, such as medication administration, and these protocols for out of hospital responses can make life and death differences. Similarly, because crisis responses can involve managing exacerbations of serious mental illness or manifestations of behavioral dysregulation by individuals with other complex and co-occurring conditions, 988 responses will need to have sound clinical leadership to guide aspects of responses. Additionally, there will need to be protocols and policies that maximize safety, provide proper assessments, and help resolve crises in the least restrictive manner possible and are guided by mental health laws and general legal and regulatory provisions.

To implement effective responses, partnerships will be key. As described throughout this paper, partnerships have been evolving in numerous innovative ways. As noted by Oss,¹⁰⁸ reports of law enforcement responding daily to overdoses and behavioral health crisis are creating an impetus for working together. Models of Law Enforcement Assisted Diversion,¹⁰⁹ such as the program started in Seattle, Washington, and the Police Assisted Recovery and Addiction Initiative and the Angel Program originating in Gloucester, Massachusetts,¹¹⁰ both demonstrated how police can assist individuals with substance use disorders rather than arresting them. They both are excellent examples of law enforcement working at the substance use/crisis interface. Other examples highlighted by Oss¹¹¹ and worth repeating include the District of Columbia’s Department of Behavioral Health’s pilot of sending an unarmed community response team to respond to behavioral health crises. This came as part of a recommendation from a police reform commission that examined practices in the District that realized that approximately 90 calls per day to police related to behavioral health crises.¹¹² And New York released data showing that consumers were more likely to accept help from their Behavioral Health Emergency Assistance Response Division (B-HEARD) pilot in Harlem, where emergency medical personnel and social workers responded to specific mental health emergency calls.¹¹³ This is a reminder of the importance of community interventions being culturally competent with the particular communities rather than over-relying on police just like the Freedom House ideas 50 years ago.

As these models emerge, staff development, recruitment, and retention are other critical issues facing law enforcement, emergency medical responders, and behavioral health. Priorities should include ensuring diversity and equity in the workforce while enhancing training and quality of services. Many of the populations of individuals encountering the crisis system, especially those at substance use, mental health, and criminal-legal system interface, may be challenging to engage. This may be especially true in communities with longstanding mistrust of the medical system. In those areas, there is a need to rebuild broken ties. These communities must enhance engagement strategies –learning in some ways from the Freedom House example or NAMI’s framework for engagement¹¹⁴-- to help attract people to services rather than inadvertently turning them off from the very supports they may need most.

Training can be a crucial area to help give law enforcement and first responders greater confidence and tools to help manage crises that they do encounter. It is critical that all parties receive sufficient training to be able to provide proper responses to behavioral health crises. Inadequate training in policing individuals with mental health is an ongoing issue, with one study going back over 15 years calling for training in topics including dangerousness, suicide by cop, decreasing suicide risk, mental health law, and liability [risk] management.¹¹⁵ Since the time of that survey, much has been done to enhance officer knowledge and skills. The International Association of Chiefs of Police OneMind Campaign aims to assist police in better preparedness for managing crises involving persons with mental illness or developmental disabilities.¹¹⁶ The Bureau of Justice Assistance has put forth a police mental health collaboration online toolkit.¹¹⁷ Law enforcement training is a cornerstone of the Crisis Intervention Team (CIT) model,¹¹⁸ which includes a robust 40-hour training curriculum that has shown effectiveness in several domains, including officers' cognitive and attitudinal outcomes.¹¹⁹ Training may also help address compassion fatigue for law enforcement faced with recurring behavioral health issues in their communities, such as overdoses due to opioids.¹²⁰ Training and protocols to answer crisis calls have also helped address suicide risk among crisis callers.¹²¹

Training can also address issues of stigma. Police see skewed samples of the population because they are generally only involved when things are not going well. Despite data showing that only 3-5% of violence towards others is attributable to people with mental disorders,^{122,123} stigma persists about persons with mental illness and beliefs that they are more dangerous than the general population.^{124,125} This can impact how law enforcement officers might respond to an individual with mental illness in crisis. It is therefore critical that training involves education about the role of stigma in perceptions of violence and mental illness. Given the role of police in protecting all individuals, it is also essential for training to include information that individuals with mental illness are more likely to be victims of violent crime, theft, assault, and rape than be a perpetrator.¹²⁶

Lastly, training can also enhance community partnerships,¹²⁷ especially when different disciplines train together. Michigan, for example, through its Mental Health Diversion Council, has been working with partners in behavioral health, law enforcement, and emergency medical responses to build out more recently updated cross-training for all three systems together.¹²⁸

Other specific approaches may also help improve outcomes in overall crisis service delivery. Trauma-informed services are recognized as increasingly important given the recognition of the high proportion of behavioral health- and justice systems-involved persons who have trauma histories both as victims of and witnesses to violence.¹²⁹ Studies demonstrate that histories of childhood trauma contribute to more behavioral health challenges.¹³⁰ SAMHSA has defined trauma by understanding the three "E's" of events, experiences of the event(s), and the effect of those experiences on an individual. It has noted how people can recover and adapt with the right supports despite their traumatic experiences.¹³¹ In its guiding documents, SAMHSA further recommends that a system is trauma-informed through a framework of four "R's," which means that the system *realizes* the impact of trauma and the potential for recovery when it *recognizes* signs of trauma and *responds* by developing policies and practices to help avoid and *resist retraumatization*. For law enforcement working with emergency medical responders and behavioral health crisis response systems, these partnerships should aim to be trauma-informed.

Stakeholders must also address exposure to trauma among the workforce to provide the most responsive crisis services. First responders are at increased risk of mental health challenges related to their work, with high levels of exposure to traumatic events, challenges with their work schedules, and

general work-related stressors unique to their roles.¹³² Similarly, first responders and response teams have raised concerns about the impact of exposure to suicides in crisis work on their personal lives.¹³³ Law enforcement officers are not immune from these experiences. Studies have shown them to be at increased risk of cardiovascular disease, psychological stress,¹³⁴ and even suicide.¹³⁵

Several law enforcement programs around the country have recognized that their own risk of trauma can impact their well-being and have begun to implement peer support programs.^{136,137} For example, police in Miami-Dade, Florida, surveyed its police and fire departments to better understand how their workforce is dealing with post-traumatic stress disorder. As part of their efforts to expand CIT training, they have begun developing and delivering models to better support officer mental health.¹³⁸ These models should be considered a basic necessity for all crisis responders- from call center employees to those out in the field delivering direct services. The experience of COVID-19 has further highlighted these needs.

Finally, there has been increasing attention to peer support engagement in the crisis response at the interface of law enforcement, mobile crisis teams, and emergency responders. The Boston Medical Center Emergency Services Program (BMC ESP) provides robust and integrated crisis services in several communities, including Boston, Cambridge, Somerville, and Fall River, and actively engages health professionals, mental health staff, and peer specialists to provide crisis services that “respects the dignity” of those served.¹³⁹ A learning community to enhance and help train peer support professionals in crisis services is offered by C4 Innovations.¹⁴⁰ Roles of “forensic peers”- those with criminal legal and behavioral health system personal experience has also been shown to have a role for individuals with co-occurring disorders in the justice system.¹⁴¹ Peer-led warmlines at the call center interface have also been promulgated, and NAMI has actively promoted these lines and disseminated information about them.¹⁴² History illustrates that peers can play a vital role in helping individuals in crisis and can assist at the law enforcement interface to extend the types of supports for individuals being served.

Conclusion

The promise of 988 reimagines an alternative pathway for individuals in crisis related to mental health, substance use, or other emotional challenges that will result in decreased suicides, safe crisis resolution, and linkage to needed treatments. In such a system, the role of law enforcement is de-emphasized in favor of utilizing responders through call centers and mobile teams along with emergency medical supports that can arrive on the scene as best equipped to manage mental health and substance use challenges in the community. This change is a critical step forward in reducing the numbers of individuals with behavioral health challenges from being arrested and needlessly criminalized and hopefully lowering the disproportionate numbers of individuals with mental illness whose lives end with encounters with law enforcement that have gone awry. In those situations, there are no winners, and the traumatic impact on communities of these incidents continues for generations. At the same time, law enforcement responders will always be needed for situations that are high-risk or where criminal conduct is an issue. As such, it is critical to enhance partnerships, develop policies, and plan for and support crisis services that acknowledge and coordinate roles of all responders. By taking these steps, the promise of 988 has greater potential to maximize safety while shaping improved outcomes that recognize the vulnerability of all humans to emotional crises and meet the unique needs of any individual in crisis, anywhere, at any time.

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Strategies and Considerations for Providing a More Equitable Crisis Continuum for People of Color in the United States



No. 5

NASMHPD

Ready to Respond:
Mental Health Beyond Crisis and COVID-19

September 2021

Strategies and Considerations for Providing a More Equitable Crisis Continuum for People of Color in the United States

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Fifth in the 2021 Ready to Respond Series of Ten Technical Assistance Briefs focused on Beyond Beds, Reimagining a Sustainable and Robust Continuum of Psychiatric Care



National Association of State Mental Health Program Directors

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September 2021

Acknowledgements:

The author would like to thank the following individuals for sharing invaluable insight and providing guidance about this important topic: Megan Lee, M.A., L.P.C. and Stephanie Sundberg, M.S.W., with the Colorado Office of Behavioral Health’s Crisis Services; Matthew Canuteson, M.A., Shannon Cornwall, M.A., Darlene Ebron, Sara Riggins, L.M.S.W., and Talia Santiago with the New York State Office of Mental Health’s Bureau of Cultural Competence; Elizabeth Padilla, Kyleen Zimber, Jon Collins, Ph.D., Lori Coyner, and Stephanie Jarem, M.A. with the Oregon Health Authority; Diane Marshall, Niambi Shakir, Shelley White, and Linda Vukelich with the Minnesota Department of Human Services; Gwendolyn Green, L.M.H.C., M.C.A.P., and Danielle Hewitt, L.M.H.C. with Tampa Crossroads; Bryan Carter, Ph.D. with Norton Children’s Behavioral and Mental Health at the University of Louisville School of Medicine; Rev. Joel A. Bowman, Sr. L.C.S.W. Founding Pastor with the Temple of Faith Baptist Church in Louisville, Kentucky; Matthew Goldman, M.D., M.S with the San Francisco Department of Public Health and the University of California San Francisco; Wayne Lindstrom, Ph.D., RI International; Debra Pinals, M.D., Bryan Hepburn, M.D., Brian Sims, M.D., Aaron Walker, M.P.A., Leah Holmes-Bonilla, M.Ed., Christy Malik, M.S.W., and Nili Ezekiel with the National Association of State Mental Health Program Directors (NASMHPD); and Jennifer Bronson, Ph.D., Ted Lutterman, and Robert Shaw, M.A. with the NASMHPD Research Institute.

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Recommended Citation:

Neylon, K.A. (2021). *Strategies and considerations for providing a more equitable crisis continuum for people of color in the United States*. Technical Assistance Collaborative Paper No. 5. Alexandria, VA: National Association of State Mental Health Program Director

This work was developed under Task 2.2 of NASMHPD’s Technical Assistance Coalition contract/task order, HHSS2832012000211/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

Abstract:

In the U.S., racism affects all people of color and is an enduring, primary social determinant of racial inequities in population health and mental health.¹ The goal of this paper is to improve understanding about the roles race and racism play in an individual's social determinants of health, in particular the social determinants of healthcare access and quality, and social and community context, and how these affect the availability, accessibility, and quality of mental health crisis services. Based on a review of the literature and a series of interviews with leaders from SBHAs and providers, multiple strategies were identified to help SBHAs and providers create an equitable crisis continuum. Historic, structural racism and implicit bias have led to a lack of trust among people of color of systems that involve law enforcement and institutionalization, including the mental health crisis system. This distrust also contributes to increased stigma among communities of color. To begin to overcome these barriers and to create a more equitable and accessible crisis system, it is critical that SBHAs and providers partner with trusted community leaders (e.g., clergy in local churches) to both offer supportive services that improve social determinants of health and spread the word to build trust and engage more people of color into crisis care. To further build trust, SBHAs and providers can improve data collection and reporting processes to be more transparent and embark on quality improvement initiatives to identify strengths and weaknesses in the crisis system. While it is ideal for law enforcement to be removed from crisis response, it is often not feasible to eliminate their role completely, especially in areas with limited resources. Therefore, it is critical that law enforcement be trained in how to effectively respond to crises without the use of force, and how to divert individuals to appropriate levels of care. These strategies will help build trust with communities of color to reach out for help when they are most vulnerable. To make these changes and overcome decades, or centuries of institutional bias, it is critical to have leadership from the SBHA to self-reflect and identify opportunities for equity.

Highlights:

- Racism contributes to barriers to health and mental healthcare access and quality, which in turn affect the availability, accessibility, and quality of crisis services for People of Color.
- The police killings of unarmed Black men, the subsequent Black Lives Matter movement, and the alarming racial disparities brought to light by the COVID-19 pandemic have placed a spotlight on inequities and injustices toward People of Color in the U.S.
- Recent funding and programmatic opportunities, including American Rescue Plan funds and increases to SAMHSA's Community Services Mental Health Block Grant, as well as the upcoming implementation of 988 provide a unique chance for SBHAs and mental health crisis providers to address structural racism in their behavioral health crisis services systems.

Recommendations for the Post-COVID-19 Future:

1. Build trust with communities of color through transparent data collection and reporting; and meaningful engagement and relationship building with trusted community leaders; and the improved/reduced use of law enforcement in crisis response.
2. Address disparities by allowing providers to incorporate supportive services (e.g., housing and hygiene), and through a more representative and culturally competent workforce.
3. Provide leadership at SBHA through organizational priorities and contract language modifications that support equity.

In February 2020, the Substance Abuse and Mental Health Services Administration (SAMHSA) released the *National Guidelines for Behavioral Health Crisis Care* (referred to from here on as the “*National Guidelines*”), which outline the necessary services and best practices to deliver an effective crisis continuum. According to the *National Guidelines*, a comprehensive crisis service array includes three essential services: 1) centralized crisis lines that assess a caller’s needs and dispatch support, 2) mobile crisis teams dispatched as needed in the community, and 3) crisis receiving and stabilization facilities that are available to “anyone, anywhere, anytime.”² Ensuring each of these three components is available to “anyone, anywhere, anytime” is an admirable goal; however, as with many other system in the U.S. there is room for improvement in the public behavioral health system, and specifically the behavioral health crisis continuum, to address racial disparities to create a more equitable system for people of color. Current events and new funding and programmatic opportunities are aligning for state behavioral health authorities (SBHAs) and providers to make meaningful improvements to create a more equitable crisis service continuum for people of all races and ethnicities.

The goal of this paper is to improve understanding about the role race plays in an individual’s social determinants of health, in particular the social determinants of healthcare access and quality, and social and community context. Given that these social determinants also interplay with the availability, accessibility, and quality of behavioral health crisis services, it is critical to unpack various issues, including race and structural barriers to improving care for all people. By fostering improved understanding of these issues, this paper aims to help SBHAs, policy makers, and providers identify strategies to overcome these barriers to provide a more equitable crisis continuum, and ultimately a more equitable behavioral health service system that better meets the needs of people of color in the U.S.

Methodology

A review of the literature was conducted to understand how race affects the availability, accessibility, and quality of behavioral health crisis systems. To ensure the most relevant and timely information is included, peer-reviewed journal articles, along with publications from national associations and news articles published within the last five years are referenced; however, several relevant studies and articles older than five years are included. Because this is such a timely and important topic, and news and research about racism in U.S. is updated daily, it is likely, though not the author’s intent, that important research and news are excluded from this study.

In addition to a review of the literature, the author and colleagues from the National Association of State Mental Health Program Directors Research Institute (NRI) conducted a series of interviews during the summer of 2021 with a variety of behavioral health stakeholders, including representatives from SBHAs, state Medicaid agencies, universities, behavioral health providers, and African American/Black Christian clergy.

Key Terms: Defining Race, Ethnicity, Racism, Equality, Equity, and Intersectionality

It is important to note that race and ethnicity are two separate but related social constructs. **Race** refers to an individual’s physical characteristics (e.g., skin color, facial type), while **ethnicity** refers to common national, tribal, religious, linguistic, or cultural origins or backgrounds.³

There is consensus among scientists and researchers that race is a social, rather than biological, construct.⁴ Racism is defined as “a belief that race is a fundamental determinant of human traits and

capacity, and that racial differences produce an inherent superiority of a particular race.”⁵ While many dimensions of racism exist, the author considered three types of racism that affect social determinants of health, which in turn affect the availability, accessibility, and quality of behavioral health crisis services in the U.S.:

- **Structural Racism:** “social, economic, or political systems featuring public policies and practices, cultural representations, and other norms that perpetuate inequities”⁶
- **Institutional:** “the policies and practices within and across institutions (e.g., schools) that put certain racial groups at a disadvantage,” often to the benefit of another.⁶
- **Individual/Implicit Bias:** “face-to-face or covert actions toward a person that express racial prejudice, hate, or bias,” whether realized or not by the individual.⁶

In the U.S. racism affects all people of color and is an enduring, primary social determinant of racial inequities in population health and mental health.⁴ However, it is also critical to understand that not all people of color experience racism the same way, as all individuals have multiple identities, and those identities afford individuals different levels of societal privilege that can affect their health outcomes. This concept is referred to as **intersectionality**. For instance, people of color who identify as LGBTQIA+, are members of an underrepresented religious group, and/or have fewer socioeconomic means may be “more susceptible to negative experiences and decreased mental health... due to chronic stress stemming from the marginalized social status they have in U.S. society,” which can result in higher rates of depression and suicide risk, and a greater need for behavioral health crisis services.⁷ Therefore, it is critical for policy makers, researchers, providers, and other behavioral health stakeholders to understand and consider how these different identities affect the unique experiences of people of color so they can help improve the availability, accessibility, and quality of services for all underrepresented populations.

Understanding the difference between equity and equality is also critical. **Equality** means that “each individual or group of people is given the same resources or opportunities,” whereas **equity** “recognizes that each person has different circumstances and allocates the exact resources and opportunities needed to reach an equal outcome.”⁸

Limitations

Most data sets separate out race and ethnicity, recognizing them as two distinct but intersecting groups (e.g., that individuals may identify as both a race and an ethnicity); however, some data sets count ethnicities (e.g., Hispanic/Latino) as a distinct race. When this occurs, it is difficult to make comparisons and draw conclusions across two distinct data sets. This paper’s author makes every attempt to only include data sets that distinguish race from ethnicity, although this is not always possible. Additionally, many datasets only include data on White, Black, and Hispanic individuals, eliminating the ability to identify trends among smaller population groups (e.g., American Indian/Alaska Native, Asian, and Native Hawaiian or Other Pacific Islander).

Federal government agencies are required to adhere to the 1997 Office of Management and Budget (OMB) standards on race and ethnicity. The OMB recognizes the following races:⁹

- **White:** a person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
- **Black or African American:** a person having origins in any of the Black racial groups of Africa.

- **American Indian or Alaska Native:** a person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
- **Asian:** a person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent.
- **Native Hawaiian or Other Pacific Islander:** a person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

At the writing of this paper, the OMB standards only include “Hispanic or Latino Origin,” and “Not Hispanic or Latino Origin” for ethnicities. **Hispanic or Latino Origin** refers to a person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin regardless of race.¹⁰ There is a push for OMB to expand ethnicities to include a dedicated **Middle Eastern or North African** response category, but that has not yet been adopted.¹¹

While the author made a conscious effort to be objective and unbiased in her writing, it is important to note that she is a white woman who has never personally experienced racism, thereby eliminating the rich context and nuance that a first-person perspective would provide to this report. In an effort to reduce bias in the language of this report, the author relied on the definitions and terms outlined by the [National Institutes of Health](#) and style from the [Racial and Ethnic Identity Style Guide](#) developed by the American Psychological Association (APA).

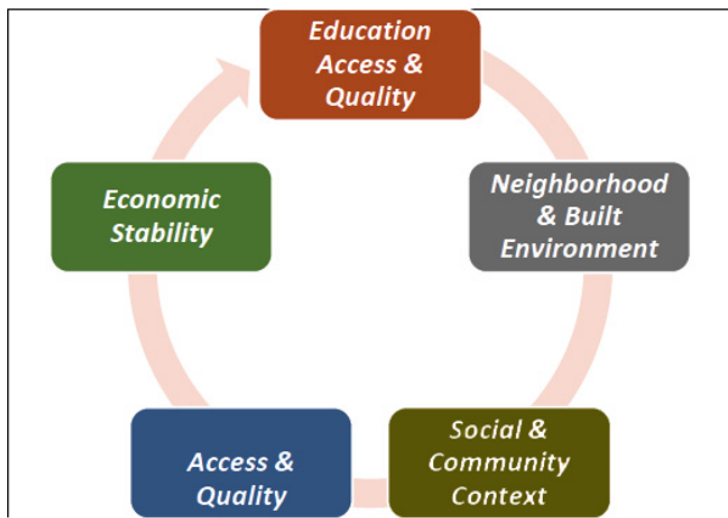
Understanding and Addressing Social Determinants of Health and Mental Health to Improve the Availability, Accessibility, and Quality of Crisis Services

A history of cruelty and oppression toward racial minorities in the U.S. persists through laws, policies, and attitudes that disadvantage people of color.¹² The disparities resulting from structural and institutional racism, and implicit bias affect everyone’s social determinants of health, usually benefitting White communities while continuing to disadvantage communities of color.

The Centers for Disease Control and Prevention (CDC) defines social determinants of health as “conditions in the places where people live, learn, work, and play that affect a wide range of health and quality of life risks and outcomes.”¹³

The five domains of social determinants of health include: 1) healthcare access and quality, 2) education access and quality, 3) social and community context, 4) economic stability, and 5) neighborhood and built environment. Each of these five domains is interconnected and influences one another, making the distinction between each domain somewhat

Figure 1: Social Determinants of Health



arbitrary. Social determinants of health have profound effects on an individual’s health and well-being.¹⁴

Individuals with certain social determinants of health are at an increased risk of poor physical health and developing a mental illness, including depression and anxiety, which may result in an increased need for crisis services.¹⁵ The World Health Organization recognizes that an individual’s social determinants of health are “shaped by the distribution of money, power, and resources at global, local, and national levels,” and that they are “mostly responsible for health inequities – the unfair and unavoidable differences in health status seen within and between countries.”¹⁶

In the U.S., people of color are at a significant disadvantage compared to White individuals in each of these five domains.¹⁷ The COVID-19 pandemic further highlights the racial inequities and disparities in the health and behavioral healthcare systems for people of color. Understanding and addressing the factors that contribute to poor social determinants of health and mental health is critical to providing high-quality services, including crisis services, and improving behavioral health outcomes for people of color.

Although all five domains of social determinants of health have implications for crisis services, this paper focuses specifically the two domains that have the most significant effects: healthcare access and quality and social and community context. Although the other domains, economic stability, neighborhood and built environment, and education access and quality are not specifically discussed in detail, all domains are so interconnected that factors related to these domains are included in the discussion.

Social Determinant of Health: Healthcare Access and Quality

Healthcare access and quality refers to the connection between an individual’s ability to access health and behavioral health care services, as well as their level of literacy related to their own health and the health and behavioral health care systems.¹⁶ Issues addressed in this domain include proximity to and availability of healthcare services, health literacy, and financing.¹⁶

People of color face significant disadvantages in healthcare access and quality compared to white individuals in the U.S. However, states and providers can take steps to improve healthcare access and quality for people of color to create a more equitable crisis continuum, including:

1. Enhance the crisis continuum so that is available to “anyone, anytime, anywhere,” regardless of an individual’s race or ethnicity²
2. Partner with community organizations and respected leaders to establish and increase engagement
3. Reduce financial barriers to care
4. Establish trust by improving the role and effectiveness of law enforcement in crisis response
5. Strategically market the availability of crisis services to diverse populations
6. Recruit and retain a representative, culturally and linguistically competent workforce that is adept at providing trauma-informed care
7. Improve diagnostic and level-of-care determination processes
8. Improve transparency and quality in crisis services through data collection and outcomes monitoring

HAQ Strategy 1: Enhance the Crisis Continuum so that it is Available to Anyone, Anywhere, Anytime

Behavioral health crisis services take many forms and look different in different communities across the U.S. While SAMHSA recommends three specific services for best practices, including centralized call

lines, mobile crisis teams, and “no wrong door” crisis receiving and stabilization facilities, individuals in crisis have traditionally relied on emergency response and safety net services, including 911, the response of emergency support and first responders (including law enforcement, fire, or ambulance), and drop-offs or admissions to general hospital emergency departments (EDs). While these services are available to “anyone, anywhere, anytime,” they are often not the most appropriate response for behavioral health crises, for either the individual experiencing the crisis or for the person or emergency team responding, which can lead to traumatic and devastating outcomes for individuals in crisis.²

When someone calls 911 for mental health crisis response, assistance often “arrives in the form of a team of police officers, many of whom do not have the information or skills they need to provide support.”¹⁸ A detailed review of law enforcement and crisis services is provided in the 2020 technical assistance paper, *Cops or Clinicians*, as well as in the 2021 technical assistance paper, *Law Enforcement and Crisis Services: Past Lessons for New Partnerships and the Future of 988*.^{19,20} Without these skills, law enforcement may not be able to effectively deescalate a crisis situation, resulting in traumatic transport to an inappropriate setting, a jail or an ED, where individuals may languish for days without addressing their mental health crisis, or worse. Carson, et al. found that “African American men in psychiatric crisis care are less likely to be given a psychiatric evaluation for hospitalization than individuals with similar symptoms who are white... and [are] more likely to be sent to jail.”²¹ There are also too many examples of tragedy when police respond to crisis calls, especially for people of color.

According to the [Washington Post’s Police Shooting Database](#), 23% of all people killed by police were identified as having a mental illness.²² Another study estimates that “76% of individuals killed in police encounters have had previous mental health treatment.”²³ One study by the Treatment Advocacy Center estimates that “people with untreated serious mental illness are 16 times more likely to be killed during an encounter with [law enforcement] than other civilians.”²⁴ Furthermore, the rate at which Black Americans are killed by police is more than twice as high as the rate for White Americans (see figure below), so even though the data on killings by police on race and mental illness are unavailable, it stands to reason that African Americans/Blacks with mental illness are killed at significantly higher rates than Whites.²² The death of Daniel Prude and Patrick Warren, Sr. are two examples of law enforcement response to a person of color experiencing a mental health crisis.

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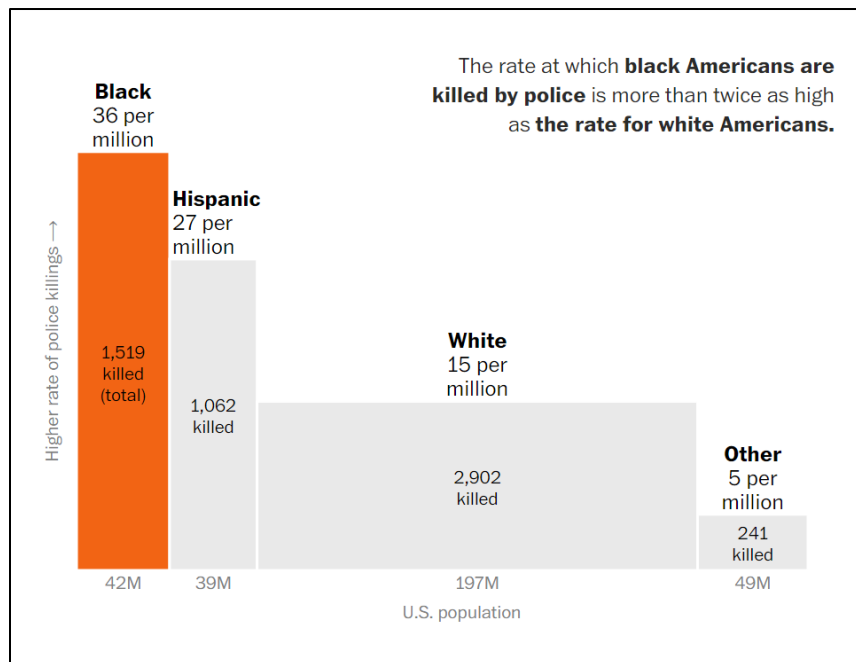


Figure 2: Number of People Killed by Police by Race, Washington Post Police Shooting Database²²

In March 2020, Daniel Prude, a 41-year-old Black man, experienced a mental health crisis. “Shoeless and shirtless,” Mr. Prude wandered the cold streets of Rochester, New York shouting fears about the coronavirus.²⁵ In an effort to help, Mr. Prude’s family called 911 twice. The first call resulted in a response from EMS (emergency medical services), who discharged Mr. Prude without effectively triaging his crisis. The second call later the same day resulted in a law enforcement response, which left Mr. Prude naked, restrained, handcuffed, hooded, and pinned face-down to the ground; after more than two minutes, he stopped breathing. Efforts to revive him only extended his life by one week, as he later died of “complications from asphyxia” in a Rochester hospital.²⁶

In January 2021, just 10 months following the death of Mr. Prude, Pastor Patrick Warren, Sr. was experiencing a mental health crisis after the poor economy associated with the COVID-19 pandemic caused him to lose his job. Mr. Warren’s family noticed behavioral changes that had them concerned enough to reach out for help. A mental health resource officer responded and escorted Mr. Warren to a local hospital for a mental health evaluation, from which he returned home later that day. The following day, his family was still concerned for his mental well-being and again sought help from the Killeen Police Department; unfortunately, no mental health resource officer was available to respond, and law enforcement officers “not prepared to handle a mental health crisis” responded instead.²⁷ This encounter proved fatal for Mr. Warren, as officers tased and shot him three times.

A robust crisis continuum, consisting of a centralized hotline, mobile crisis teams, and no-wrong-door crisis receiving and stabilization facilities that ensures proper response and follow-up care for all individuals can help provide a more equitable system for people of color, avoid tragic outcomes faced by Mr. Prude, Mr. Warren, and countless others, and begin to break the cycle of poor health and mental health.

Crisis Hotlines, 988, and Lessons from 911

Crisis hotlines are clinical call centers that operate 24-hours-per-day, seven-days-per-week. They are staffed with clinicians who provide risk assessments to individuals in crisis and engage people at imminent risk of suicide. SAMHSA’s *National Guidelines* recommends that crisis hotlines be available through phone, text, and chat methodologies to be available to as many individuals as possible. The *National Guidelines* also recommend that crisis hotlines be centrally located within a region and “offer [GPS-capable] air traffic control quality coordination of crisis care in real time.” With the Federal Communications Commission (FCC) voting in July 2020 to adopt 988 as the new three-digit dialing code to “increase the effectiveness of suicide prevention efforts,” there are new opportunities for states to create a more equitable crisis continuum for people of all races and avoid the pitfalls of 911.^{28,29}

However, people of color may fear calling a crisis hotline or the Lifeline if they expect a similar law enforcement response as calling 911; the racist history of 911 and the deaths of Mr. Prude and Mr. Warren highlight this very real possibility. Each year, nearly 100,000 trained 911 dispatch workers across the country handle 240 million 911 calls.³⁰ While the 911 crisis service system has helped to save a number of lives and de-escalate crisis situations, “the impact could well be negative,” especially for people of color.³⁰ In fact, 911 was developed in the 1960s as a way to quickly suppress protests by Black communities against segregation and police brutality.³¹ Simultaneously, the commission charged with the development of the 911 system also “encouraged the militarization of local law enforcement.”³¹ A 2019 article by Shaun King published by the

Associated Press recognized the death of Osaze Osagie, a 29-year-old Black man who was killed in State College, Pennsylvania after his family called 911 to help address his mental health crisis. Mr. King notes that “Black families remain skeptical of calling the police for help under any circumstance – and fatal encounters like the one experienced by the Osagie family confirm those doubts.”³²

Because of this fear, it is critical that crisis hotlines, and the Lifeline/988 have qualified, culturally competent crisis counselors who are effective at de-escalating crises over the phone, and that states have an effective crisis infrastructure in place so that when necessary, crisis call operators can connect individuals in crisis to care through mobile crisis response or crisis receiving and stabilization facilities. SMHAs and local providers also need to engage with their local communities to ensure that the hotline services meet the diverse needs of the community, and that individuals understand what to expect when calling the local crisis hotline or the Lifeline/988. To ensure that 988 does not cultivate the same racist response as 911, several states are ensuring that the implementation of 988 be guided by diverse advisory groups, and be available to underserved populations, including ensuring that Native American Tribes, who do not have access to 911 services, have access to 988.

Colorado Crisis Services is relying on a cultural competency advisory council to guide its activities related to the implementation of 988. Megan Lee, L.P.C., Program Manager with Colorado Crisis Services notes that “988 is multi-faceted and has a cascade of implications for the rest of the crisis system” (Lee, M., Personal Communication, 27 May 2021). Ms. Lee anticipates an increase in crisis call volume to 988, which will result in a greater need for mobile crisis response teams who are culturally and linguistically competent.

Washington State recently introduced \$1 million in legislation “to develop and operate [a 988 tribal behavioral health and suicide prevention] line and a tribal 988 subcommittee.”³³ The process will be guided by a subcommittee that includes representation from the American Indian Health Commission (AIHC) of Washington State. Vicki Lowe, Executive Director of AIHC indicates that the COVID-19 pandemic fueled this decision as leaders in the state began addressing service gaps to provide a more equitable system. In addition to the 988 Lifeline for tribes, the AIHC is working to develop the Washington Indian Behavioral Health Hub, which is a coordinating center that serves as a bridge between the sovereign tribes and the services offered by the statewide crisis system, including community services, crisis beds, and post-crisis follow-up services. Ms. Lowe’s advice for others as they plan for 988 is that “states need to think about the populations they serve so they don’t repeat the same mistakes; this is a chance to do something different.”³³

New York’s Office of Diversity and Inclusion is helping to launch 988 while ensuring that the service will be culturally competent. It is reviewing all 988 contracts to ensure that the *National Standards for Culturally and Linguistically Appropriate Services (CLAS) for Health and Health Care* are addressed, and that mechanisms to support multiple languages are included. Mr. Canuteson notes that “we have to set up 988 so seamlessly that a person doesn’t become so frustrated they call 911. This is how disparities and bad outcomes occur” (Canuteson, M., Personal Communication, 27 May 2021).

Mobile Crisis Response Teams

Mobile crisis response teams are groups of two or more crisis counselors that are centrally “available to reach any person in their service areas in their home, workplace, or any other community-based location of the individual.”² As described in the *National Guidelines*, mobile crisis response teams serve a broader range of individuals in less-acute crisis situations, but are capable of referring individuals to crisis receiving and stabilization facilities should they need a higher level of care. A survey of mobile crisis response teams shows that they are able to stabilize approximately 70% of all crisis calls in the community and make referrals to facility-based care for the remaining 30%.² There are several benefits to the use of mobile crisis response teams. One benefit is that they meet people in the community, ideally where people feel more comfortable, and try to address the crisis where the crisis is occurring without use of force. Another benefit of mobile crisis response is that it eliminates the need for law enforcement response when appropriate.

Colorado Crisis Services provides mobile crisis response in a diverse neighborhood of the City of Aurora. Aurora, while predominantly White, is significantly more diverse when compared to the rest of the state. As of 2016, 84.2% of Colorado residents are White, whereas only 61.1% of City of Aurora are White.³⁴ The remaining 39% of the population is composed of Black/African Americans (16%), Asians (6%), individuals who identify as having two or more races (5%), Native Hawaiian or Other Pacific Islander (>1%), and American Indian/Alaska Native (>1%).³⁴ Colorado Crisis Services was struggling to serve this marginalized community. They received feedback from a resident, who stated, “you’re failing my community; we will not reach out for services because we don’t trust you” (Lee, M., Personal Communication. 27 May 2021). After a series of conversations, it was determined that the staffing composition of the mobile crisis response team led to distrust in the community because the people responding were masters-led clinicians who “did not look like them,” and were not members of the community. Many behavioral health providers, and crisis services providers in particular, in the State of Colorado “are well-meaning white women in their 30s” who may have trouble engaging with communities of color (Lee, M., Personal Communication. 27 May 2021).

Colorado Crisis Services’ mobile crisis teams are required to have a masters-level clinician respond to calls for service, who will sometimes bring along another person. Learning from this, to gain the trust of the community leadership at Colorado Crisis Services initiated planning for a pilot program with the mobile crisis provider in Aurora, allowing for the masters-trained clinician to bring known community leaders with them to respond to calls. As part of this pilot, the crisis encounter with the mobile crisis team was to be led by the familiar community leader, with the masters-trained clinician conducting the assessment. This approach helps the mobile crisis team to gain respect in the community, allowing them to better engage people into care. The pilot is now being explored by the City of Aurora. While the pilot is potentially no longer with Colorado Crisis Services, it did “open the door to thinking about the things that inadvertently get in the way of an effective community response” (Lee, M., Personal Communication, 27 May 2021).

Following this pilot with the crisis team in the City of Aurora, Colorado Crisis Services began modifying its contract language to allow CMHCs to create a pilot program to “eliminate any contract requirement that gets in the way of making a program work the way it is supposed to” (Lee, M., Personal Communication, 27 May 2021). The contract language specifically states:

Pilot Programs. The Office of Behavioral Health (OBH) or contractor may propose pilot programs

to evaluate potential solutions or enhancements to Administrative Service Organization services. Pilots must be time-bound. OBH may waive conflicting contract terms for the duration of the pilot period as needed to allow for services to proceed according to the pilot proposal terms. If a pilot program is deemed successful at the conclusion of the pilot period, the parties may negotiate an amendment to this Contract to the extent necessary to accommodate the pilot activities (Lee, M., Email Correspondence, 27 May 2021).

Feedback from several of the states interviewed for this paper addresses changing contract language to ensure that “services are reaching individuals of different identities and intersections, and to focus on priority populations from areas that have been historically excluded from services” (Sundberg, S., Personal Communication, 27 May 2021). The changes that Colorado has made to its contracting language allowing flexibility in provider response and the prioritizing of specific groups helps to achieve equity among underrepresented populations; however, beyond changes to contract language, SBHAs and providers also need to consider how the contracts are awarded, and strive to improve the culture and expand the array of the organizations in which they work.

To create more equitable contracts and policies related to crisis services, understanding the needs of diverse communities is critical. One step to ensuring equity and inclusion is to create an advisory group that guides the development of new policies and contracts. Stephanie Sundberg, M.S.W., Manager of the Transition-Age Youth and Healthy Transition at the Colorado Office of Behavioral Health, recommends that advisory groups be representative of the communities a provider organization or SBHA serves, and not just by including one or two representatives from an underrepresented group, which is harmful and tokenizes individuals in a symbolic gesture with no substance, purpose, or power in their participation. In addition to meaningful representation, SBHAs can implement a variety of feedback mechanisms, allowing advisory group members to share their ideas for discussion, and open them up for feedback and implementation, ultimately creating intentional space for shared decision making to make substantial change. It is also important that these community engagement efforts are upheld through the allocation of resources, including funding, to make change happen. The programs an SBHA funds clearly identify the agency’s priorities.

Crisis Receiving and Stabilization Facilities

Crisis receiving and stabilization facilities provide short-term (usually less-than 24 hours) observation and crisis stabilization services to individuals in a home-like, non-hospital environment. Best practices for crisis receiving and stabilization facilities outlined in the *National Guidelines* recommend that they have a dedicated first responder drop-off area that allows law enforcement to quickly return to their patrol; include beds within a “real-time regional bed registry system” that is accessible by the crisis call center and mobile crisis teams “to support efficient connection” to needed resources; and coordinate connections to follow-up services.² The “no wrong door” approach allowing law enforcement to easily drop individuals in crisis off reduces the likelihood that people experiencing a crisis will be brought to jails or other inappropriate inpatient settings.

Incorporating bed registries into the model also allows SBHAs to monitor the utilization of crisis services, including demographic information about who uses the services, to ensure that services are accessible and available to all communities. Ensuring that crisis services are working as intended (i.e., diverting people away from inappropriate settings of jails and hospitals, reducing law enforcement involvement, and connecting to follow-up care), bed registries in 20 states are monitoring the following data points:³⁵

- Diversion: 12 states
- Connection to treatment: 8 states
- Volume of service usage: 8 states
- Connections to law enforcement: 5 states
- Outcomes: 5 states
- Public perception of the system: 1 state

Crisis Follow-Up Care

Regardless of how an individual interacts with the crisis system, it is critical that they be provided with follow-up care that meets their mental health and cultural needs. Colorado Crisis Services found that individuals in diverse communities tended to not follow through with care post-crisis intervention, “because the clinical services were not something they would ever engage in” (Lee, M., Personal Communication, 27 May 2021). The feedback Colorado Crisis Services received from the marginalized communities was that follow-up would be more effective if it included non-traditional treatment that supports the individual. The change to the contract language allowing CMHCs to pilot programs that modify their approach gives the crisis provider flexibility to ask the community, “where do you feel supported,” and “how can we get you connected with those supports?” (Lee, M., Personal Communication, 27 May 2021). The revised contract language also allows CMHCs to refer to non-traditional providers, including community organizations like the Boys and Girls Club, and local churches. Megan Lee, L.P.C., Crisis Program Manager with the Colorado Office of Behavioral Health’s Colorado Crisis Services, notes that “just because a person doesn’t want to access clinical services, it doesn’t mean that we (Colorado Crisis Services) can’t support them” (Lee, M., Personal Communication, 27 May 2021). Changing the crisis model to serve the whole person can help to stabilize or improve an individual’s economic station, encourage future engagement with behavioral health services, and potentially reduce the need for crisis services in the future.

HAQ Strategy 2: Partner with Community Organizations and Leaders to Establish Trust and Increase Engagement

Individuals of different races have different help-seeking behaviors that are formed by their cultures and experiences living in a White-dominated society that fails to recognize their differences and expects them to be the same as the dominant community. Understanding the differences between and within cultures will help providers identify community partners who can help to better engage with people of color. Rev. Joel Bowman Sr., L.C.S.W., and Founding Pastor at the Temple of Faith Baptist Church in Louisville, Kentucky notes that “help-seeking behaviors of African Americans are different than the general population. African American communities tend to be more communal than White communities, and when Black families are having issues, either they will deal with those issues within the family system, including fictive kin, or they may go to their faith tradition” (Bowman, J., Personal Communication, 6 July 2021). An avenue for outreach includes partnerships between SBHAs, health care providers, and others with traditionally Black churches. To gain respect and trust in the African American/Black communities, it is critical that SBHAs and crisis providers first gain trust with the senior pastors of the churches. According to Rev. Bowman, “the dynamic with Black churches is different from White churches; without the buy-in of the senior pastor of the church, it will be difficult to gain the trust and respect needed to engage the community.” Brian Sims, M.D., Medical Director at NASMHPD reiterated the importance of engaging the faith community improve mental health outcomes, noting

that “the Black pastor is such a pivotal person in the Black community, if we’re going to make significant inroads, it has to start with clergy” (Bowman, J., Personal Communication, 6 July 2021).

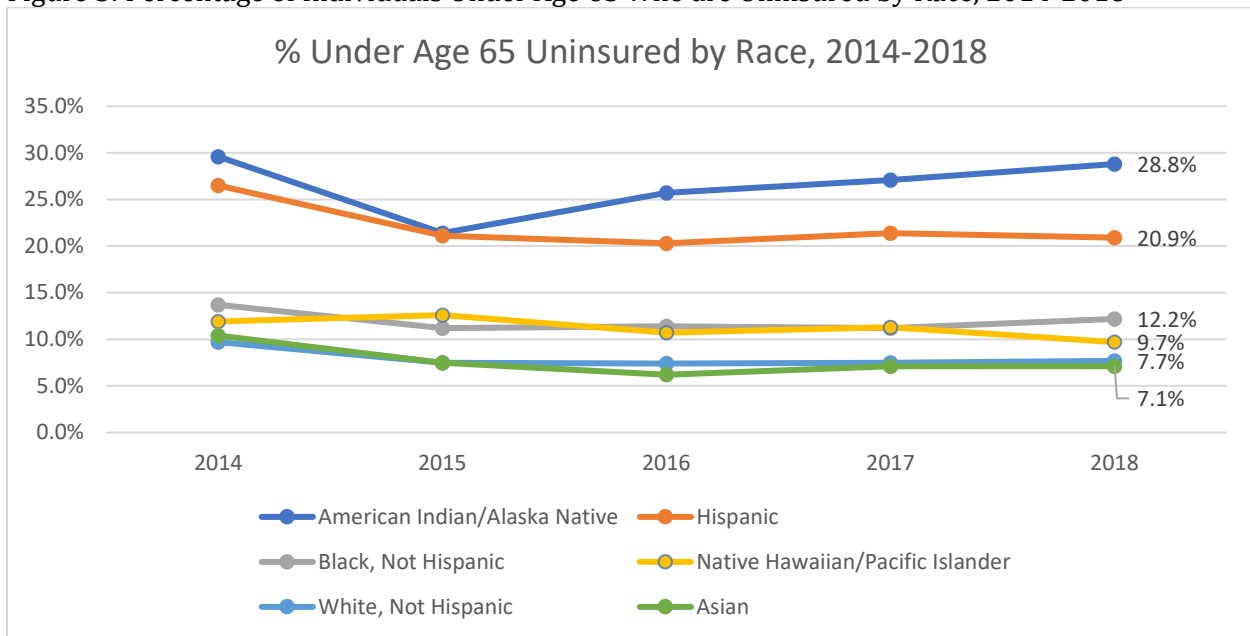
Reinforcing Rev. Bowman’s comments, Bryan Carter, Ph.D., Service Chief of the Pediatric Consultation-Liaison Service at Norton Children’s Hospital in Louisville, Kentucky notes that immigrant communities and communities of color tend to place more value in the family unit (Carter, B., Personal Communication, 6 July 2021). Engaging family members in crisis care can help to establish trust in the system and increase participation in follow-up services. And, as discussed above, Colorado Crisis Services has found similar barriers to engagement with its racially diverse communities, and has allowed providers to engage community partners, including churches and local Boys and Girls Club chapters to provide non-clinical, supportive services. Sometimes, according to Gwendolyn Green, L.M.H.C., M.C.A.P., Executive Director with Tampa Crossroads, the simplest thing that a provider can do to increase engagement with a given community is to “simply ask people, instead of making assumptions, about what their barriers are and to see if we can correct those” (Green, G., Personal Communication. 29 June 2021).

In addition to partnerships with community organizations and churches, SBHAs and providers “should not be afraid to reach out to foundations or through the state college systems” (Canuteson, M., Personal Communication, 27 May 2021). Mr. Canuteson indicates that “foundations are hot on equity right now,” and provide an opportunity for SBHAs and providers to enhance their crisis continuum and ensure equity at the state and provider levels (Canuteson, M., Personal Communication, 27 May 2021). Providers can also partner with historically Black colleges and universities (HBCUs) to ensure that crisis services are available to their diverse student populations (Bronson, J., Personal Communication, 12 August 2021).

HAQ Strategy 3: Reduce Financial Barriers to Care

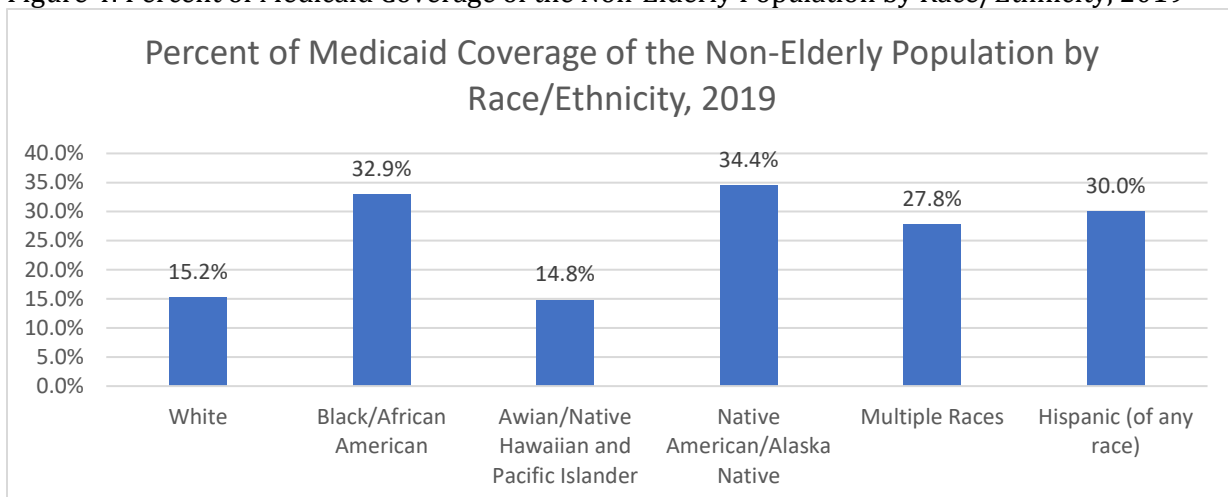
The cost of accessing mental health crisis services, whether real or perceived, is a barrier to people of color. People of color experience poverty at higher rates than White people in the U.S. According to 2018 Census Data, 25.4% of Native Americans, 20.8% of Black/African Americans, and 17.6% of Hispanics (of any race) are impoverished, compared to 10.1% of Whites and Asians.³⁶ Similarly, African Americans, Hispanics, and Native Americans are uninsured at higher rates than Whites and Asians (Figure 3).³⁷ A lack of reliable income and financial resources can prevent people from seeking help, and when they do seek help, the quality of services available is often inconsistent or inadequate.

Figure 3: Percentage of Individuals Under Age 65 Who are Uninsured by Race, 2014-2018³⁷



In 2019, an estimated 75 million individuals were enrolled in Medicaid in the U.S.³⁸ Medicaid provides coverage to low-income individuals, pregnant women and children, and individuals with disabilities. Since 2014, Medicaid coverage is available to individuals up to 133% of the federal poverty level in the 39 states that elected to expand Medicaid (as of August 2021). Medicaid is the third largest payer in the U.S. healthcare system behind private insurance and Medicare, representing 16% of national healthcare spending in 2019.³⁸ People of color are more likely to be covered by Medicaid than White individuals. (See Figure 4 on the following page.) However, even with Medicaid coverage, people of color face barriers to care as many mental health providers do not participate in Medicaid plans; certified peer support specialists who can bring representation to the behavioral health crisis workforce are often not paid a living wage, reducing their utilization; and supportive services, such as housing and other social services may not be fully covered to promote equitable social determinants of health.

Figure 4: Percent of Medicaid Coverage of the Non-Elderly Population by Race/Ethnicity, 2019³⁸



To overcome these barriers, the Oregon Health Authority is applying for an 1115 Medicaid Demonstration Waiver that creates “A Pathway to Health Equity.”³⁹ Oregon’s Waiver application for the five-year period between 2022 and 2027 strives to achieve equity by:

- Ensuring access to coverage for all people in Oregon, by “ensuring enrollment of people who are eligible and expanding eligibility for those at risk for becoming uninsured.”³⁹ According to the Oregon Health Authority, an estimated 6% of people in the state do not have health insurance, with some communities of color, including Hispanics, Native Americans, and African Americans/Blacks less likely to be uninsured than Whites or individuals who identify as two or more races.⁴⁰ To do this, Oregon Health Authority proposes ensuring people who are newly enrolled in the Oregon Health Program during the COVID-19 pandemic maintain appropriate coverage; ensure that people who are eligible for Oregon Health Program are aware of the program and become enrolled; and enhance coverage continuity for both children and adults and expand coverage to low-income individuals who are not currently eligible for the Oregon Health Program.³⁹
- Creating an equity-centered system of health that requires coordination and collaboration with systems beyond healthcare. To achieve this goal, the Oregon Health Authority will improve transitions across systems, close gaps in coverage and care, and provide “defined packages of services and supports for health-related social needs related to this transition.”⁴¹
- Transitions from incarceration and institutional settings are especially challenging when an individual does not have stable housing or is going through a tumultuous life event. Often, individuals “are left to navigate multiple complex systems independently because [Oregon’s] state health care system is not designed to align and coordinate with other social systems and providers in a way that allows everyone to come together to support people in accessing systems more seamlessly.”⁴¹ The Oregon Health Authority notes that “these challenges are exacerbated for tribal members, communities of color, and people with disabilities as systems often lack the infrastructure and resources to provide culturally and linguistically appropriate care...[that] do not meet people where they are.”⁴¹ To achieve this goal, the Oregon Health Authority proposes enhancing care coordination and non-clinical supports to support transitions across outcomes; remove barriers to culturally and linguistically competent health services; and prioritizing marginalized communities to promote health equity across the system.⁴¹
- Encourage flexibility in spending on “upstream drivers of health” while prioritizing meaningful, equitable improvements in healthcare.³⁹ Through this action, the Oregon Health Authority plans to create a global budget, which entails flexible, service-integrated payments for the state’s Coordinated Care Organizations (CCOs). This model enables CCOs to coordinate care across multiple sectors of health (physical, mental, and oral), and affords them the flexibility to provide individuals with housing and food supports which promotes equity in the communities the CCOs serve. To achieve this goal, the Oregon Health Authority will hold the CCOs accountable to a sustainable cost growth target, and incentivize CCOs “to focus on health equity, prevention, and high-quality services that... reduce costs.”⁴² In addition, the Oregon Health Authority will “use innovative rate methods to set global budgets that encourage efficiency and upstream investments” that address health-related social needs,” and will hold CCOs accountable to meeting these needs.⁴²

- Reinvest government savings across systems “to address larger or statewide problems that no single community can fix on its own.”³⁹ The Oregon Health Authority will prioritize these savings on funding initiatives that address large-scale barriers related to health and health equity. Savings will be directed toward individual communities “to improve the social, economic, and physical environment.”⁴³ To achieve the most effective and efficient progress, the Oregon Health Authority and the CCOs will “partner with community leaders to identify and operationalize strategies to eliminate health inequities.”⁴³

To ensure these goals and processes are meeting the needs of the diverse communities the Oregon Health Authority services, it will enhance and expand its feedback mechanisms to collect and understand the concerns and needs of providers, advocates, and community members.⁴² In conversations with representatives from the Oregon Health Authority, there is excitement that this 1115 Demonstration Waiver will allow the state to “smooth out the edges of coverage” to ensure that people are receiving high-quality, culturally and linguistically competent services that meet the specific needs of each community (Coyner, L., Personal Communication, 16 June 2021). The state emphasized the value of data, both quantitative and qualitative, in ensuring that this new waiver works for everyone. Using data, gathering and meaningfully considering input from the communities, and collaborating with respected community leaders will help the Oregon Health Authority gain trust within marginalized communities. This will be especially helpful in the delivery of crisis services in the state, so that when people are the most vulnerable, they will feel comfortable reaching out for the help they need and will receive linguistically and culturally competent care in return.

HAQ Strategy 4: Establish Trust by Improving the Role and Effectiveness of Law Enforcement in Crisis Response

Some communities of color have a mistrust of law enforcement and those who engage with them. This is particularly acute for African American/Black communities, due to the legacy of slavery and Jim Crow laws. Although it is ideal to remove law enforcement from all crisis response, and many advocacy organizations are encouraging just that, it is not always practical or safe to do so. Rev. Bowman underscores the need for law enforcement reform. Although there are calls to “defund the police,” Rev. Bowman suggests that this call to action does not adequately describe the intent or the need behind the movement and can create excessive divisiveness which halts progress. Rev. Bowman indicates a need for “a paradigm shift. ‘Defund the police’ has become a sensitive issue, when what it really means is the reallocation of funds for improved services and police reform” (Bowman, J., Personal Communication, 6 July 2021). He suggests that reform needs to happen at the local level, where if police need to be involved mental health practitioners work alongside them to respond to calls for service, and for police to receive appropriate, thorough, culturally competent training on how to de-escalate crisis situations.

Equipping law enforcement with the literal and figurative tools they need to safely and effectively respond to crises in the community, especially those serving remote areas where crisis infrastructure (e.g., workforce, mobile crisis response teams, and crisis receiving and stabilization facilities) may be lacking, is critical. Technology can be used by law enforcement responding to crisis to connect individuals directly to a mental health crisis counselor. Training in cultural competence and Crisis Intervention Team (CIT) education can provide law enforcement with the skills necessary to safely and effectively de-escalate crises in the field, which can help lead to more trust among people of color that law enforcement response, when it is the only option, can meet their needs.

Technology can be used to allow law enforcement instant access to a behavioral health crisis counselor while responding to crisis situations. Having ready access to a behavioral health crisis counselor can help the officer feel more confident knowing they have the tools to de-escalate crisis situations without force. Grand Lake Mental Health Center (GLMHC) in Oklahoma equips all officers with iPads within its catchment area. The iPads allow officers to immediately connect with health providers to help triage crisis situations in the field, reducing the need for transport. In addition, the tablets offer an application for officers to immediately connect to behavioral health providers that specialize in providing crisis services to law enforcement. Now, law enforcement officers have a way to reach out for help if they need to speak with someone after witnessing a traumatic event, and to deal with any personal and professional challenges that have an impact on their own mental health. Beyond officers, GLMHC also offers iPads to each recipient of their crisis services upon discharge, allowing individuals to immediately connect to qualified staff, 24/7. In 2015, prior to the launch of this program, more than 1,100 individuals were admitted to inpatient beds in the region, and almost all were brought in by police. After GLMHC opened new crisis facilities, allowing officers to utilize the tablets and facilitate quick drop offs, the number of patients admitted to an inpatient crisis bed in 2020 plummeted to one person. The program was funded through an incentive program by the SBHA. In 2016, Oklahoma's SBHA incentivized providers to develop alternatives to inpatient care to reduce hospitalization rates and allowed the CMHCs to use funds that would normally support inpatient services on community-based services instead.⁴⁴

CIT was developed in Memphis, Tennessee to train police to respond more effectively and safely to mental health crisis encounters. Officers trained in CIT are equipped with skills to calm individuals experiencing a mental health crisis and divert them to mental health services instead of jail. The objectives of CIT are to reduce injuries to officers and the individuals in crisis, promote decriminalizing individuals with a mental illness, and reduce the stigma associated with the experience of a mental health crisis. Training officers in CIT, especially in areas with limited mental health resources, results in more effective crisis services when the services recommended in the *National Guidelines* may be unavailable. In order to integrate CIT into the culture of law enforcement, Karl Rosston, M.S.W., suicide prevention coordinator with the State of Montana recommends training all new recruits during their training at the Academy. To ensure that the CIT model works for all people, it is imperative that the cities and counties that implement the program fully integrate it "into the wider behavioral mental health care system and route calls away from police."⁴⁵ Ron Bruno, a 25-year police veteran and current Executive Director of Crisis Team International notes that "if you keep throwing money at training officers, and that's all you do, and not address the system around mental health care, you'll continue to have nothing but problems."⁴⁵ Enhancing the mental health crisis continuum, and training officers in de-escalation techniques and how to recognize implicit bias will help create a more equitable response to mental health crises by law enforcement.

Another approach to diversion during or after a crisis is the implementation of the Sequential Intercept Model. [SAMHSA's GAINS Center](#) developed the five-point Sequential Intercept Model, which identifies five opportunities along the criminal justice continuum to divert individuals with mental illness from the criminal justice system and prevent further involvement in the system. The original five "intercepts" include: 1) Law Enforcement (including calls to 911); 2) Initial Court Hearings/Initial Detention; 3) Jails and Courts; 4) Re-entry; and 5) Community-based criminal justice supervision with behavioral health supports.⁴⁶ Recently, a new intercept, Intercept Zero, has gained support, encouraging system alignment to connect individuals with

care before a behavioral health crisis emerges.⁴⁷ Intercept Zero includes the use of community services, peer warm lines, and crisis lines. The Sequential Intercept Model can help to reduce racial disparities across systems, to reduce the higher arrest rates and disparities in referrals to diversion programs among people of color, to reduce the disproportionate prevalence of pretrial incarceration and higher bail amounts for people of color, and to improve the chance that people of color are more likely to receive restorative mental health services rather than punitive consequences.⁴⁸

CIT and the Sequential Intercept Model can help to reduce rates of incarceration among individuals experiencing a mental health crisis, including persons of color, which can contribute to higher rates of incarceration – a factor within the social and community context determinant of health.

Another way to reduce law enforcement involvement in crisis response and to reduce the potential for force, which is disproportionately used against people of color, is to embed crisis counselors within the 911 system.⁴⁹ While several models are in operation today, the first to implement this model is The Harris Center in Houston. The Crisis Call Diversion (CCD) program embeds behavioral health specialists in the City of Houston 911 Dispatch Center. It is a partnership between the Houston Police Department (HPD), the Houston Fire Department (HFD), and The Harris Center for Mental Health and Intellectual and Developmental Disabilities. When a person calls into 911 experiencing a crisis, the 911 dispatcher identifies and redirects mental health related, emergent, non-life-threatening calls for service to bachelor's trained crisis counselors and away from first responders. Since its launch in 2016, the CCD program has successfully diverted individuals away from law enforcement and fire department response and saved more than \$2 million in resources for the HPD, and nearly \$4.5 million for HFD. Recently, in March 2021, the CCD program began working with The Harris Center's Mobile Crisis Outreach Rapid Response to dispatch teams in the community to respond to calls for service that could not be de-escalated over the phone.

To reduce the unnecessary reliance on law enforcement, which can lead to unnecessary incarceration or use of force which disproportionately affects people of color, New York City recently launched a similar program where crisis counselors are embedded within precincts in the Harlem and Harlem East neighborhoods of the city.⁴⁹ In November of 2020, Mayor Bill de Blasio announced plans to have mental health workers replace police officers in response to some 911 calls, beginning in 2021. The program is being piloted in three neighborhoods in the Borough of Harlem, which is nearly 62% Black.⁵⁰ The neighborhoods participating in the pilot accounted for the most 911 calls in the city in 2019. The primary goal of the program is to “avoid bad outcomes from police interactions with individuals experiencing a mental health crisis.”⁵¹ When a person in crisis calls 911 from one of these neighborhoods, rather than police response, two Fire Department EMTs and one social worker will respond. The program is available 16 hours per day. It has been so successful that Mayor de Blasio anticipates extending the project city-wide.

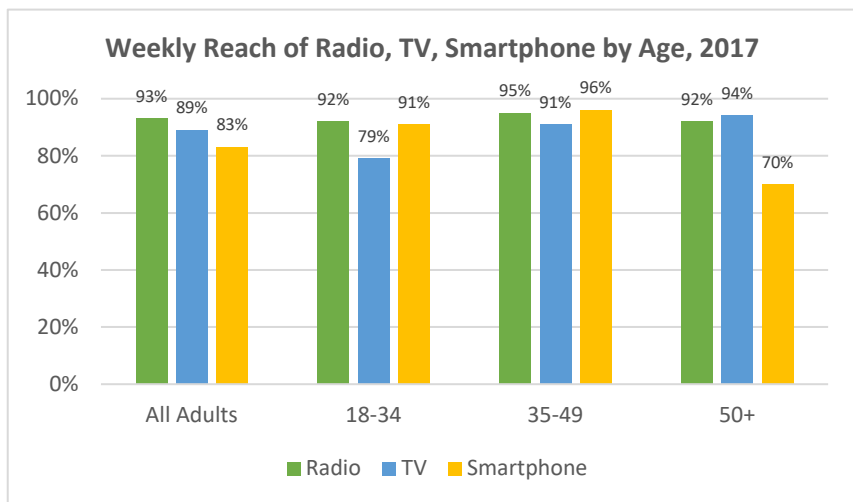
HAQ Strategy 5: Market the Availability of Crisis Services to Diverse Populations

One of the most common barriers identified during the interviews for this paper is that “many people [of color] don't know what crisis services are, or what they can do” (Shakir, N., Personal Communication, 9 July 2021). This lack of knowledge can help spur fears among marginalized communities that by calling for help in a crisis, law enforcement or child protective services will respond to the call, and instead of receiving help for a behavioral health crisis, they may be arrested (or worse, as in the cases of Mr. Prude, Mr. Warren, and Mr. Osagie and countless others) or have their children removed from their

home. Niambi Shakir, a crisis team lead with the Minnesota Department of Human Services, noted that “there is often a misconception of what crisis can do among under-represented communities,” with some people expecting a SWAT-style response (Shakir, N., Personal Communication, 9 July 2021). One way to overcome this uncertainty and mistrust is by marketing the availability of crisis services specifically to these diverse populations, by addressing what crisis services are, how they can help, and what to expect.

A variety of platforms exist to advertise the availability of behavioral health crisis services, including television, radio, and mobile applications (“apps,” including social media). Marketing efforts can be targeted based on the population an SBHA or provider is trying to reach. The overall reach of each platform differs and varies by age and race. According to a 2017 study by Nielsen, “radio reaches more Americans each week than any

Figure 5: Weekly Reach of Radio, TV, Smartphone by Age, 2017⁵²

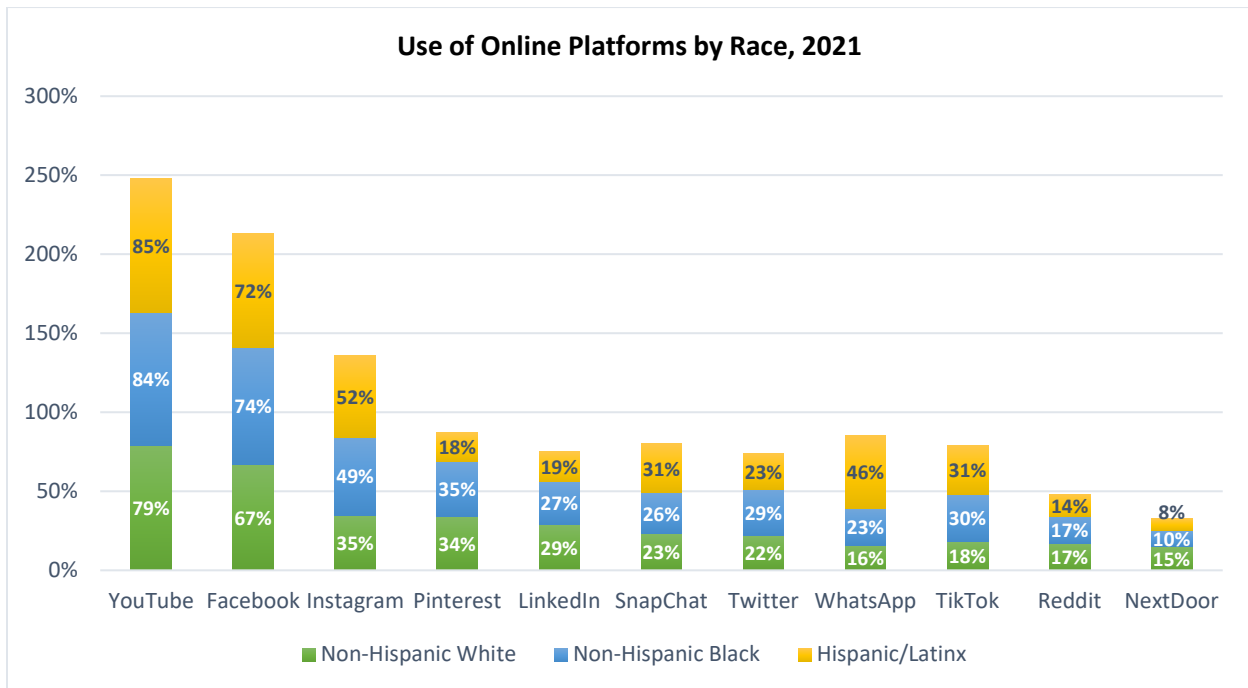


other platform,” although this may have shifted since fewer people are commuting during the current COVID-19 pandemic.⁵² Figure 5 shows the weekly reach by age group as a percentage of the U.S. population for each radio, TV, and smartphone apps.⁵²

Looking beyond the age categorizations, Nielsen also found that “African-American and Hispanic listening audience[s] now accounts for one-third of the [traditional radio] listening audience, and that number continues to grow.”⁵³ Traditional radio reaches 93 percent of African American/Black consumers, and 98% of Hispanic consumers. African American/Black and Hispanic consumers also frequently consume radio through smartphones and other streaming devices. African American/Black listeners tend to listen between 3:00pm and 7:00pm, while Hispanic listeners are more likely to listen to the radio between 10:00am and 3:00pm.⁵³

In addition to radio and TV, SBHAs can leverage social media to reach a wider, younger, and more diverse audiences to promote their services, including crisis services. YouTube, Facebook, and Instagram are the most widely used social media platforms in the U.S. Facebook has the widest reach across all adults ages 18 and over, while Instagram and SnapChat have the widest reach among youth ages 13 to 17. Non-Hispanic Black and Hispanic individuals are most likely to use YouTube (84% and 85%, respectively, of adults in each demographic group), and are least likely to use NextDoor (10% and 8%, respectively’ see Figure 6 below).⁵⁴

Figure 6: Use of Online Platforms by Race, 2021⁵⁴



As discussed further on in the paper, behavioral health stigma among communities of color is a significant barrier to preventing individuals with behavioral health needs from seeking help, even in times of crisis.⁵⁵ social media has the added benefit of normalizing the conversation around the need for behavioral health services in racially and ethnically diverse communities. A 2018 study by the Pew Research Center found that 80% of Black social media users “value the platforms for magnifying issues that aren’t usually discussed,” and 60% of Hispanics and Whites felt the same.⁵⁶ Collaborating with respected public figures, including athletes, to spread the word about behavioral health crisis services can help legitimize the value they offer, especially in diverse communities.

Regardless of which platform is used to promote the availability of behavioral health crisis services, the language used related to behavioral health also matters in overcoming stigma and increasing engagement. At least two states, Colorado and Minnesota, noted that instead of using the terms “mental health” or “behavioral health,” their outreach efforts to diverse communities focuses instead on “mental wellness” (Lee, M., Personal Communication, 27 May 2021; Shakir, N., Personal Communication, 9 July 2021).

Lessons and Examples from Colorado Crisis Services

In 2019, [Colorado Crisis Services](#) began strategizing how to best promote its crisis services, especially to diverse, underserved communities (including rural communities and communities of color). During their market research, they also discovered, and were surprised to find that radio had a broad reach, especially among the Hispanic communities within the state. Based on these findings, Colorado Crisis Services began marketing its services on the radio specifically to Hispanic communities. While it took a while to see gains, the efforts to promote crisis services on the radio became “fruitful, especially with Spanish-speaking audiences” (Lee, M., Personal Communication, 27 May 2021).

In addition to the targeted radio ads, Colorado Crisis Services has also tailored its social media and print materials for diverse populations, including Hispanic and Black communities. To promote its messages and services on social media, Colorado Crisis Services collaborates with local leaders, and recruits a more diverse group of social media influencers in Colorado to make its messaging more representative. One lesson learned in using social media influencers is that SBHAs and providers should provide guidance on what the messages should cover, while allow the social media influencers to craft their own messages, using language that resonates within their own communities.

Figure 7: Colorado Crisis Services Twitter Campaign Example⁵⁷

A comprehensive list of marketing campaigns used by Colorado Crisis Services, including examples designed to better engage people from Black and Hispanic communities, as well as reaching rural and LGBTQIA+ communities can be found online (<https://coloradocrisiservices.org/toolkit/general-campaign/>). An example of a Twitter post developed by Colorado Crisis Services is provided above.⁵⁷

HAQ Strategy 6: Recruit and Retain a Representative, Culturally and Linguistically Competent Workforce that is Adept at Providing Trauma-Informed Care

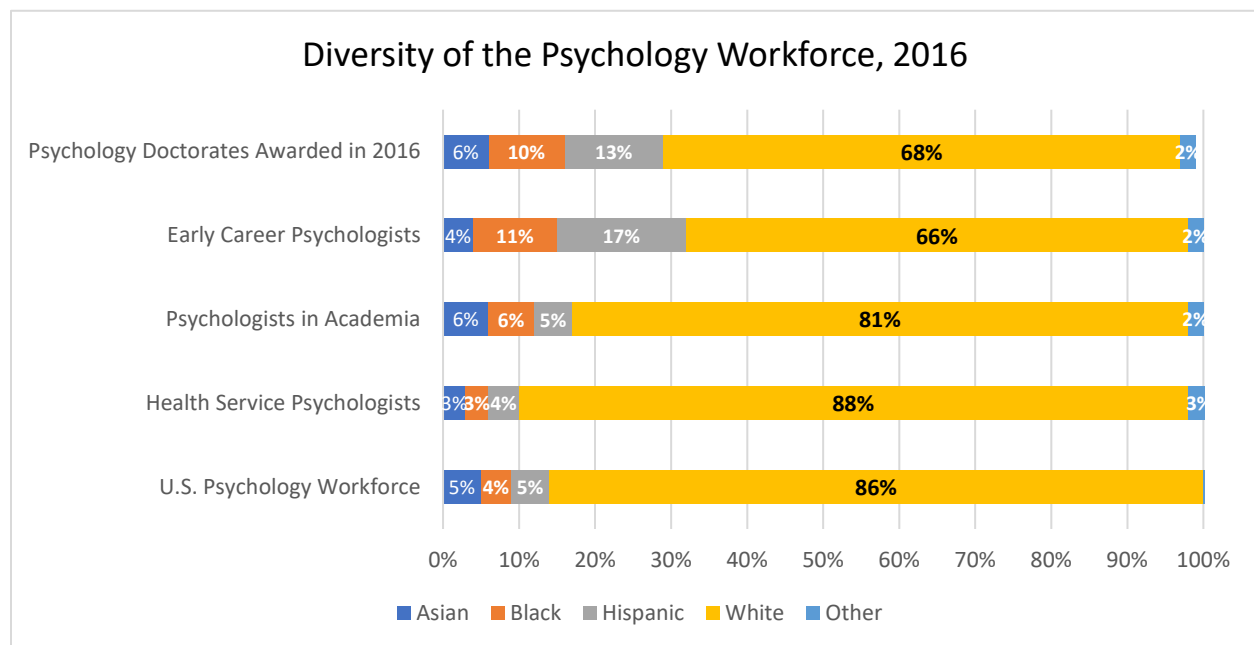
A culturally responsive and diverse workforce in mental health services overall, and in crisis services, can help restore faith in the system by people of color, and lead to better outcomes for all consumers. A 2020 technical assistance paper, *Crisis Services: Addressing Unique Needs of Diverse Populations*, provides an overview of the considerations, challenges, and implications for the workforce in various crisis settings.¹⁹ Investing in efforts to recruit and retain a representative workforce, training providers in the National CLAS Standards and trauma-informed care, and recruiting a diverse workforce from local institutes of higher education, including historically Black colleges and universities (HBCUs) will help to engage marginalized communities.

Recruitment and Retention

A lack of diversity in the behavioral health crisis workforce, and behavioral health workforce overall “contributes to poor quality of care, including higher rates of misdiagnoses among racial minorities.” Research supports Rev. Bowman’s assertion that there is a lack of representation among people of color, and there are a relative few who he would consider to be culturally competent in terms of engaging African American clients and patients” (Bowman, J., Personal Communication, 6 July 2021).

Data from 2016 show that the behavioral health workforce is predominantly white for psychologists, although for early career psychologists there is some improvement in diversity. See Figure 8.

Figure 8: Diversity of the Psychology Workforce⁵⁸



Oregon is taking steps to bolster and diversify its behavioral health workforce through significant investments from the legislature. In June of 2021, the Oregon Legislature passed a \$474.4 million behavioral health package that addresses a wide variety of social determinants, including “housing and residential services to community programs to incentives that attract people to the workforce and developing mobile crisis units.”⁵⁹ \$80 million of these funds will go toward two incentive programs to increase Oregon’s behavioral health workforce, including scholarships, and grants for providers to offer clinical supervision for licensure.⁶⁰ Language in [HB2949](#) specifically charges the Oregon Health Authority to increase the behavioral health workforce to improve access culturally responsive behavioral health services, and to help transition individuals from incarceration back into the community, which will have profound effects on improving social determinants of health for people of color in Oregon, as Oregon’s jail population is disproportionately represented by people of color.⁶¹

“To improve access to culturally responsive behavioral health services by tribal members, people of color, lesbian, gay, bisexual and transgender youth, veterans, persons with disabilities, individuals with intellectual and developmental disabilities, individuals with limited English proficiency, individuals working in correctional facilities, residents of rural areas and other

underserved communities. [The bill also] directs [the Oregon Health Authority] to provide funding to counties, community mental health programs and organizations to support individuals to transition from incarceration back into [the] community.”⁶¹

In addition to strengthening the clinical workforce, Shelley White, a Peer Policy Representative with the Minnesota Department of Human Services, recommends integrating peers into crisis response teams to improve diversity and representation (White, S., Personal Communication, 9 July 2021). She notes that peers can be incredibly helpful in crisis situations when they meet an individual experiencing a crisis in the community and wait with them until a clinician arrives. On the substance use side in Minnesota, they have been successful recruiting African American/Black peers, Muslim peers, and individuals from the large Somali community.

Recruiting from Local Institutes of Higher Education, Including Historically Black Colleges and Universities

Local universities and colleges, including HBCUs, are an excellent resource for SBHAs and providers to develop and recruit a diverse, representative, and culturally and linguistically competent crisis workforce. Providing scholarships to people of color to pursue degrees in mental health and covering the costs of licensure upon graduation help reduce the barriers many people of color face when entering the behavioral health workforce. SAMHSA sponsors an [Historically Black Colleges and Universities Center of Excellence in Behavioral Health](#), which provides up to \$500,000 in funding to states to “recruit students to careers in the behavioral health field to address mental and substance use disorders, provide training that can lead to careers in the behavioral health field.”⁶²

National Standards for Culturally and Linguistically Appropriate Services (CLAS)

In 2013, the Department of Health and Human Services’ Office of Minority Health (OMH) published the final, enhanced National CLAS Standards. According to OMH, “cultural and linguistic competency strives to improve the quality of care received and to reduce disparities experienced by racial and ethnic minorities and other underserved populations.”⁶³ Research suggests that through the implementation of CLAS initiatives at the provider level, “there are substantial increases in provider knowledge and skill acquisition, and improvements in provider attitudes toward culturally and linguistically diverse populations.”⁶³ In addition to more competent care, that implement the CLAS Standards also show an increase in patient satisfaction, higher levels of patient-reported quality of care, and increased levels of trust in the organization.⁶³ The CLAS Standards are made up of one Principle Standard, and 14 standards within three themes:

- Principle Standard 1: Provide effective, equitable, understandable, respectful, and quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs.
- Theme 1: Governance, Leadership, and Workforce
 - Standard 2: Advance and sustain governance and leadership that promotes CLAS and health equity
 - Standard 3: Recruit, promote, and support a diverse governance, leadership, and workforce
 - Standard 4: Educate and train governance, leadership, and workforce in CLAS
- Theme 2: Communication and Language Assistance
 - Standard 5: Offer communication and language assistance

- Standard 6: Inform individuals of the availability of language assistance
- Standard 7: Ensure the competence of individuals providing language assistance
- Standard 8: Provide easy-to-understand materials and signage
- Theme 3: Engagement, Continuous Improvement, and Accountability
 - Standard 9: Infuse CLAS goals, policies, and management accountability throughout the organization’s planning and operations
 - Standard 10: Conduct organizational assessments
 - Standard 11: Collect and maintain demographic data
 - Standard 12: Conduct assessments of community health assets and needs
 - Standard 13: Partner with the community
 - Standard 14: Create conflict and grievance resolution processes
 - Standard 15: Communicate the organization’s progress in implementing and sustaining CLAS

OMH has made available a series of tools and educational courses for behavioral health providers to improve their knowledge and understanding of the CLAS standards:

- [An Implementation Checklist for the National CLAS Standards](#) with a CLAS Action Worksheet and CLAS Testimonials to evaluate whether and how well an organization is currently implementing the CLAS Standards.⁶⁴
- [Think Cultural Health](#) is a free training for behavioral health providers. This 5.5-hour program contains four courses and is approved for up to 5.5 contact hours for counselors, nurses, psychologists, psychiatrists, and social workers; other professionals can earn a Statement of Participation. After completing these courses, participants will be able to describe how culture, cultural identity, and intersectionality are related to behavioral health and behavioral health care; describe the principles of cultural competency and humility; discuss how our bias, power, and privilege can affect the therapeutic relationship; discuss ways to learn more about a client’s cultural identity; describe how stereotypes and microaggressions can affect the therapeutic relationship; explain how culture and stigma can influence help-seeking behaviors; describe how communication styles can differ across cultures; identify strategies to reduce bias during assessment and diagnosis; and explain how to elicit a client’s explanatory model.⁶⁵

Training Providers in Trauma-Informed Care

Training providers in trauma-informed care and providing trauma-informed services can help to engage people of color into treatment, including crisis services, and ensure their continued involvement in services.

Trauma is “the result of an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting, adverse effects on [an] individual’s functioning and mental, physical, social, emotional, or spiritual well-being.”⁶⁶ People of color are at higher risks for exposure to collective and individual trauma, due to racial trauma that has been passed through generations.⁶⁷ “People who experience extreme events of racial discrimination can develop racial trauma, which can lead to [post-traumatic stress disorder] and worsen symptoms of

anxiety or depression.⁶⁸ Trauma “affects self-esteem and self-worth, especially when your skin color is weaponized against you.”⁶⁷ Understanding the effects of trauma and minimizing future trauma are key components to trauma-informed care.

Trauma-informed care “views trauma through an ecological and cultural lens and recognizes that context plays a significant role in how individuals perceive and process traumatic events.”⁶⁶ Trauma-informed care requires that providers anticipate and avoid institutional processes and individual practices that may retraumatize individuals with a history of trauma. Trauma-informed care values consumer participation in the development, delivery, and evaluation of services.⁶⁶

HAQ Strategy 7: Improve Diagnostic and Level-of-Care Determination Processes

A 2014 review of the literature by Schwartz and Blankenship spanning a 24-year period found that African American/Black individuals are diagnosed with psychotic disorders at a rate three-to-four times higher than White individuals. Relatedly, African Americans/Blacks are almost five times more likely to be diagnosed with schizophrenia when compared to Whites admitted to state psychiatric hospitals. A similar trend was found among Hispanic, who were “disproportionately diagnosed at a rate more than three times higher than [White] Euro-Americans with a schizophrenia diagnosis.”⁶⁹ Additionally, African Americans/Blacks discharged from state hospitals were “discharged more often with an unspecified diagnosis, such as psychosis not otherwise specified,” compared to their White counterparts.⁶⁹ In a March 2021 Washington Post article, King Davis, Ph.D., former commissioner of the Virginia Department of Mental Health, indicated that one of the reasons for high rates of schizophrenia diagnoses is the perception that “Black people, Black men” in particular as “being on the cusp always of violence and danger.”⁷⁰ In the same article, Arthur Whaley, Ph.D., M.P.H., notes that “when African Americans respond or react to oppression in an appropriate way, because those experiences are not shared by the mainstream they’re seen as paranoid, and they’re misdiagnosed.”⁷⁰

In his 30 years of service as a licensed social worker, Rev. Bowman has seen a lot of misdiagnoses among African American/Black youth, particularly for ADHD (attention-deficit, hyperactivity disorder) and oppositional defiant disorder (ODD). Contributing to this problem, notes Dr. Carter, is that diagnostic instruments and guides, including the Diagnostic and Statistical Manual of Mental Disorders (DSM) and Intelligent Quotient (IQ) tests were developed based on the experiences of White, Euro-centric populations. Inappropriate diagnostic tools and guides that are not culturally sensitive can categorize individuals with different cultural backgrounds as being lower functioning, “which is a whole other form of discrimination,” as the clinical conclusion is usually that they are not able to be remediated, and therefore not given the same opportunities as White youth (Carter, B., Personal Communication, 6 July 2021). Dr. Carter also notes that, “if we’re going to be equitable in terms of diagnosing, the mental health community will have to look at a different diagnostic tool or significantly overhaul what we have because generally White males are the population upon which those instruments are based” (Carter, B., 6 July 2021).

SAMHSA’s *National Guidelines* recommend that crisis providers use the LOCUS (Level of Care Utilization System), which “is a tool designed to assess level of care needs of individuals experiencing psychiatric and addiction challenges... [it] provides a single, easy-to-use instrument that can be used in a multitude of settings to clarify an individual’s needs and identify services appropriate to address those needs.”⁷² By using a standardized tool, it can help providers overcome their implicit bias and reduce unnecessary

institutionalization among people of color. However, more research may need to be done to ensure that these standardized instruments are equitable in their evaluations.

Dr. Carter also recommends that, “rather than starting with pathology, providers should take a strengths-based approach during evaluation,” to avoid inappropriate diagnoses and level-of-care placements (Carter, B., Personal Communication, 6 July 2021). A strengths-based approach to mental health “moves the focus away from deficits of people with mental illnesses and focuses on [their] strengths and resources” (Carter, B., Personal Communication, 6 July 2021).⁷¹

Investing in a representative workforce that is culturally and linguistically competent can help reduce inherent bias among providers. According to Schwartz and Blankenship (2014), “the inclusion of cultural information within a diagnostic formulation is critical because a diagnostic judgement leading to a potential misdiagnosis can have several lasting negative effects for consumers, ranging from having an inaccurate healthcare record and complications related to insurance coverage, to being prescribed antipsychotropic medications and potential death resulting from self-stigma-induced suicide... Diagnoses can greatly influence the future of a consumer’s healthcare, including participation in and trust of the healthcare system generally.”⁶⁹ If clinician biases can be overcome through cultural competence training, then the trend of misdiagnoses may begin to decrease.

Strategy 8: Improve Transparency and Equality in Crisis Services through Data Collection and Outcomes Monitoring

It is critical for states and providers to collect demographic data and monitor outcomes of crisis services so that racial inequities in crisis services can be understood and addressed. Data collection can also be useful to establishing trust among communities of color. Dr. Sims recommends that to overcome mistrust of the system, SBHAs and providers should be “flooding [the public] with transparency” (Sims, B., Personal Communication, 8 March 2021).

Many states and crisis providers do not collect demographic data about the people that use their crisis services. An internet search of SBHA data dashboards that display information about crisis services and race yields few results. However, Utah and Wisconsin both publish data about race and service access. These reports can serve to strengthen trust in the system through transparency, and enable the states to monitor the availability, accessibility, and quality of services for people of color.

Utah publishes reports for health status by race and ethnicity every five years. While not specific to crisis services or mental health, the [2015 report](#) analyzes a wide array of health issues, including health care quality and accessibility, poverty, infant and maternal health, injuries and violence, and chronic disease.⁷²

In February 2021, Wisconsin’s Department of Health Services published the report, [Differences in Crisis Services and Psychiatric Hospitalization across Race and Ethnicity](#).⁷³ The report provides information on the types of unique individuals that receive crisis services in the states by race and ethnicity and identifies potential barriers to care. The report also reviews how crisis services and psychiatric hospitals are used by people of color.

By collecting, analyzing, and publishing these data, Utah’s Department of Health and Wisconsin’s Department of Health Services demonstrate their commitment to improving the quality of healthcare services and life for people of color in the state.

One reason that so few states publish data about who uses crisis services is that data collection in the midst of a crisis is inappropriate, as the first priority should be responding to the crisis. However, once a crisis is triaged, it is important for the crisis counselor, whether on the phone or in person, to schedule a follow-up for post-crisis care. At this point, data can be collected that helps states and providers better understand who is being served, the quality of services being offered, and the outcomes of the crisis interventions. Once an individual is in the system, it becomes easier to identify them and track their outcomes should any subsequent services be needed. SAMHSA's *National Guidelines* recommend that crisis call centers collect "data elements such as phone numbers of Medicaid-enrolled or privately insured individuals" so that they can be "combined with Caller-ID technology."²

Social Determinant of Health: Social and Community Context

Social and community context (SCC) refers to the "connection between characteristics of the contexts within which people live, learn, work, and play, and their health and wellbeing."¹⁶ Factors within this domain that are pertinent to the delivery of crisis services include stigma and incarceration.

Understanding and addressing the role stigma has on how people of color approach crisis services, and the effects of incarceration on communities of color are critical to providing a more equitable crisis continuum. Strategies that SBHAs and providers can use to address social and community context include:

1. Understand and address stigma in diverse communities
2. Reduce incarceration through diversion and improved law enforcement response

SCC Strategy 1: Understand and Address Stigma in Diverse Communities

In addition to reluctance to reaching out for crisis services due to mistrust, many communities of color attach stigma to seeking mental health services and see the need for care as taboo or controversial. For many African Americans/Blacks, their "story is one of perseverance and resilience," with the thought that "after all, we survived slavery; surely we can survive 'sadness' or 'anxiety.'"⁷⁴ Many Asian communities stigmatize mental health due to the emphasis on family honor and purity, whereas mental illness may be seen as shameful, untreatable, and weak.⁷⁵ According to Diana Lorenzo, M.D., a psychiatrist with the Cleveland Clinic's Center for Behavioral Health, "many Latinos would prefer to ignore [mental health] conditions over talking about them openly."⁷⁶ Understanding the stigma associated with mental illness among Native American/Alaska Natives is complex, as "the concept of mental illness has different meanings and is interpreted in various ways," as Native American and Alaska Natives are not one homogenous group.⁷⁷ These attitudes cause some people of color "to believe they are exempt from mental health issues."⁷⁷ These beliefs can be dangerous because they cause individuals to avoid or delay critical treatment.

Ms. Green indicates that the first step in overcoming or reducing stigma is understanding how each culture perceives mental health treatment. Reframing the system from one that is punitive for people of color to one that offers problem solving options, even if mandated treatment, would go a long way (Green, G., Personal Communication, 29 June 2021). Other strategies to reduce stigma in communities of color to increase engagement with the system include reducing stigmatizing language (as Colorado Crisis Services did by changing "Mental Health" to "Mental Wellness) and engaging with community partners, as described above, to normalize the conversation around mental health and crisis services.

Focused marketing campaigns similar to what Colorado Crisis Services has implemented can also be effective at normalizing the conversation around mental health and wellness. By engaging community leaders and other respected individuals (e.g., athletes, celebrities, influencers) and allowing them to use their own voice to promote messages can help engage communities of color and destigmatize mental health crisis care.

Other strategies for overcoming stigma within communities of color include:⁷⁶

- Removing the language barrier so that providers can fully understand the needs and desires of their clients. While interpreters can be helpful, a linguistically diverse workforce is most effective at interpreting cultural nuances and jargon.
- Due to stigma associated with mental health, people of color may be more likely to reach out to a primary care physician for help rather than a dedicated mental health or crisis provider. Ensuring that primary care providers have the right tools to help diverse populations identify a mental health crisis and normalize the need for mental health services can help to destigmatize the need for mental health services within diverse communities.
- Many communities of color emphasize the family unit more than White families in the U.S. Recognizing the value of the family unit and encouraging family involvement in care, including how to get someone the help they need in a crisis, can help normalize the need for mental health services in communities of color. By involving family members up front, it is also more likely that an individual will return for follow-up appointments post-crisis.

SCC Strategy 2: Reduce Incarceration through Diversion and Improved Law Enforcement Response

The U.S. jail census has nearly quadrupled since 1970, with admissions reaching 11 million annually.⁴⁴ Although people of color make up 20.8% of the U.S. population, they are significantly over-represented in prisons and jails, especially African Americans/Blacks. In 2019, African Americans/Blacks accounted for 26.6% of all arrests, even though they only make up 13.4% of the U.S. population. Similar trends exist for American Indians and Alaska Natives, where the percentage of arrests (2.4%) is nearly twice the percentage of their population (1.3%). Data also show that people of color are more likely to be arrested for minor offenses, including disorderly conduct and vagrancy. See Figures 9 and 10 on the following page.

Figure 9: Percentage of Arrests Compared to Overall Population by Race, 2019⁷⁸

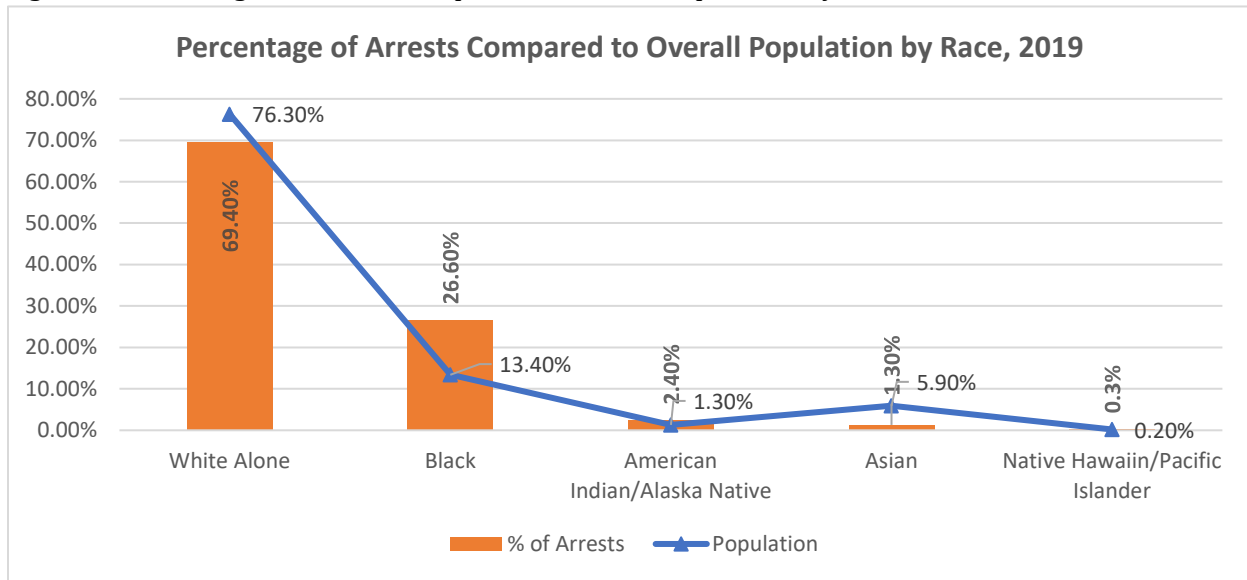
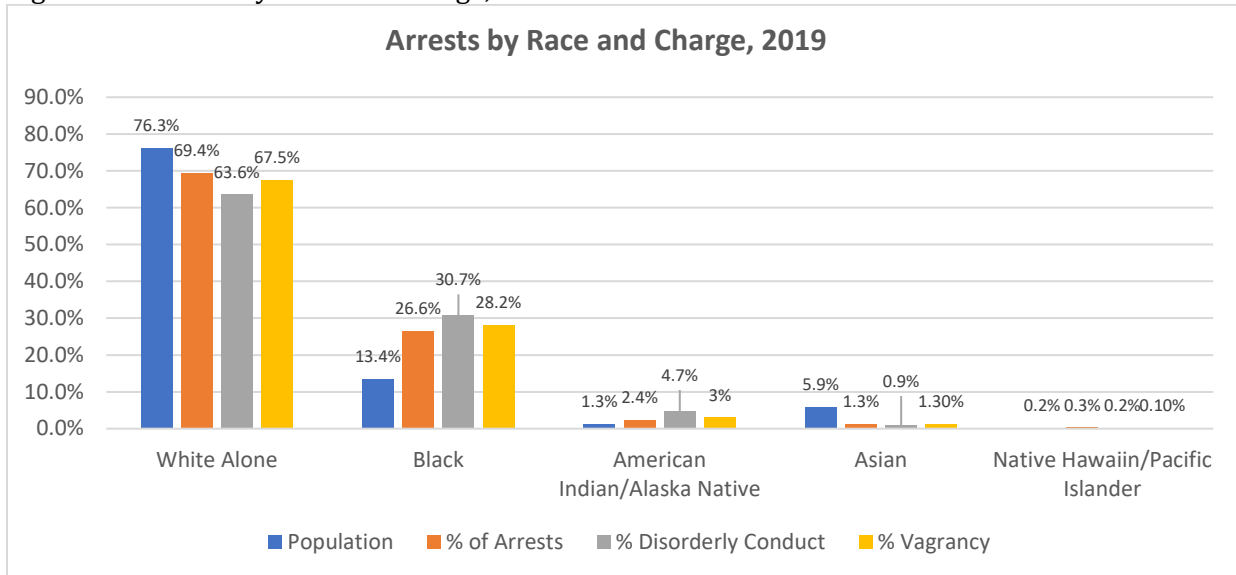


Figure 10: Arrests by Race and Charge, 2019⁷⁹



Ms. Green observes that even though Tampa Crossroads operates in a predominantly diverse neighborhood, the majority of their clients are White. Even though the services provided by Tampa Crossroads are covered through a grant from the county, few people from the local area seek out their services. In addition to needing more outreach and education on how to access services, her theory for why her clientele are predominantly White is because “more people of color are sent to jail, and not given the option for treatment” (Green, G., Personal Communication, 29 June 2021). Research supports her theory. A study by Carson, et al. in 2014 found that African American/Black men experiencing a psychiatric crisis are less likely to be evaluated for hospitalization than White individuals with similar symptoms and are more likely to be sent to jail where they are less likely to receive behavioral health care than their White counterparts.²¹

Reducing law enforcement response to crisis services and enhancing training for the times when they need to respond will help reduce incarceration among people of color experiencing a crisis. Diverting individuals from jail will help to break the cycle of incarceration, and the trauma associated with incarceration by allowing parents to reunite with their children, return to work, and participate in their communities.

Making Change Happen: Leadership from the State Behavioral Health Authority

Meaningful change toward a more equitable system requires leadership from the SBHA. Several financial opportunities recently became available that SBHAs can leverage to bolster their crisis continuum, including the American Rescue Plan Act of 2021 (ARP), and an expansion of SAMHSA's Mental Health Community Services Block Grant (MHBG) Plan.

The ARP "establishes a new state option to provide community mobile crisis intervention services for a five-year period beginning April 2022."⁸⁰ To incentivize states to use these funds for the implementation of crisis services, "the law allows for an 85% enhanced federal matching rate for qualifying services for the first three years of state coverage."⁸⁰ Additionally, the ARP also includes \$15 million in state planning grants to support the development of a Medicaid state plan amendment or waiver request to take up the option. In addition, as part of the ARP, Congress added \$1.4 billion to the MHBG with SAMHSA emphasizing to the SBHAs that these additional funds can be used to support crisis services.⁸¹ The amount of funds each state receives through the ARP varies, ranging from \$181,128 in Wyoming, to nearly \$9.5 million in California. In addition, as part of the fiscal year 2021 MHBG appropriations to SAMHSA, Congress added a new 5% set aside (nearly \$42.3 million) dedicated to supporting mental health crisis services.

Multiple SBHAs recognize the need for, and value of diversity and representation in behavioral health services. Some states, like New York, have gone beyond simply recognizing the value of diversity and representation to creating an Office of Diversity and Inclusion to manage the cultural shift required to create a more equitable system.

For many decades, New York's Office of Mental Health (OMH) has convened a stakeholder advisory group to focus on special populations. The stakeholder group consists of representatives from marginalized populations in the state, including people of color, residents from rural areas, veterans, and individuals whose native language is something other than English. This stakeholder group advocated that there be staff within OMH to work with the commissioner and other state leadership to focus on diversity and inclusion. At first, the office consisted of a secretary and "maybe one other person," and was not very high up in the SBHA (Canuteson, M., Personal Communication, 27 May 2021). Around two years ago, priorities began to focus on diversity and inclusion within the SBHA and the office was elevated officially to the Office of Diversity and Inclusion, complete with senior staff and an executive team. Following the murder of George Floyd in May of 2020, the Office of Diversity and Inclusion was elevated further to report directly to the commissioner, and now has five staff. Funding for this Office comes directly from the SBHA through State General Funds.

The Office of Diversity and Inclusion is tasked with ensuring that all OMH requests for proposals address the CLAS Standards and address equity in a strong way, including diversifying and training the workforce to be more culturally competent. The Office of Diversity and Inclusion is also responsible for promoting

the message of inclusion and providing guidance on best practices for a culturally competent workplace. When working with providers, Matthew Canuteson, M.A., Director of the Bureau of Cultural Competence recommends “giving people information in concrete, tangible bites” that can be used incrementally to improve their programs (Canuteson, M., Personal Communication, 27 May 2021). Messaging should be “consistent and clear. It’s important that people aren’t getting 18 separate ideas on what they should be doing!” (Canuteson, M., Personal Communication, 27 May 2021).

Mr. Canuteson acknowledged that the current political climate is creating opportunities to move the conversation around race and ethnicity forward; however, there is some fear that once the world settles and COVID is over, that some focus and attention on these important issues will be lost. Because of this risk, and the potential for changing priorities, it is important that structural changes to the organization of the SBHA be made to sustain the SBHA’s leadership in diversity and inclusion. The Office of Diversity and Inclusion is also trying to show providers how to make lasting changes within their own organizations that support equity.

When asked what the biggest barrier to change is? Mr. Canuteson simply stated, “racism.” He notes that racism is the number one issue that his office deals with. To overcome these challenges, they train from a model that everyone has bias. It takes leadership for an agency, a provider, and an individual to self-reflect and find ways to improve. Leadership from the SBHA can create avenues for communication to openly discuss bias, and it helps if there is leadership from other agencies, too. (Canuteson, M., Personal Communication, 27 May 2021).

Oregon’s Health Authority is an example of state leadership in equity. In 2020, as part of its response to the COVID-19 pandemic, the Oregon Health Authority established a goal to eliminate health inequities by 2030. The Oregon Health Authority’s Policy Board developed the following definition of equity that highlights its values in achieving the strategic goal:⁸²

“Oregon will have established a health system that creates health equity when all people can reach their full health potential and well-being and are not disadvantaged by their race, ethnicity, language, disability, gender, gender identity, sexual orientation, social class, intersections among these communities or identities, or other socially determined circumstances. Achieving health equity requires the ongoing collaboration of all regions and sectors of the state, including tribal governments, to address:

- The equitable distribution or redistribution of resources and power; and
- Recognizing, reconciling, and rectifying historical and contemporary injustices.”⁸²

This goal is the driving force behind its 2022-2027 1115 Medicaid waiver application, its COVID-19 vaccine distribution campaign, and all other activities within the state’s health system. By establishing this overarching goal, it has allowed the Oregon Health Authority, and the state legislature, to focus on one thing to make change. In order to achieve this goal, the Oregon Health Authority realizes that it “must meaningfully engage with communities most impacted and often left out of the decisions that affect their lives.”⁸²

To meaningfully gather input from marginalized communities and guide efforts related to equity, the Oregon Health Authority’s Division of Equity and Inclusion went out to communities around the state. State representatives gave presentations in these communities to gain interest in the input process, and then offered space for the community to meet in the evenings outside of work hours, at times that

would be most convenient to the community. To ensure candidness during these sessions, state representatives were not present; however, facilitators from the community were on hand to guide the discussion and take notes. From these community engagement sessions, the Oregon Health Authority had analysts review the notes and categorize recommendations by themes. Some of the feedback the Oregon Health Authority received is that peer support specialists need to be utilized more to create a more representative workforce, and that both quantitative and qualitative data should be used to guide decision making and quality improvement efforts. This feedback is guiding the state's equity efforts moving forward. According to the state, "this was the most effective community engagement process" (Coyner, L., Personal Communication, 16 June 2021).

Conclusion

In the U.S., racism affects all people of color and is an enduring, primary social determinant of racial inequities in population health and mental health.¹ Historic, structural racism and implicit bias have led to a lack of trust among people of color of systems that involve law enforcement and institutionalization, including the mental health crisis system. This distrust also contributes to increased stigma among communities of color. To begin to overcome these barriers and to create a more equitable and accessible crisis system, it is critical that SBHAs and providers partner with trusted community leaders (e.g., clergy in local churches) to both offer supportive services that improve social determinants of health and spread the word to build trust and engage more people of color into crisis care. To further build trust, SBHAs and providers can improve data collection and reporting processes to be more transparent and embark on quality improvement initiatives to identify strengths and weaknesses in the crisis system. While it is ideal for law enforcement to be removed from crisis response, it is often not feasible to eliminate their role completely, especially in areas with limited resources. Therefore, it is critical that law enforcement be trained in how to effectively respond to crises without the use of force, and how to divert individuals to appropriate levels of care. These strategies will help build trust with communities of color to reach out for help when they are most vulnerable. Within any system, there will be resistance to change, particularly if the organization or system has amassed a lot of influence, and is part of a large, bureaucratic system. This resistance can lead to an oppressive culture; however, looking to SBHA leadership to make a commitment to equity and inclusivity helps move the efforts forward.

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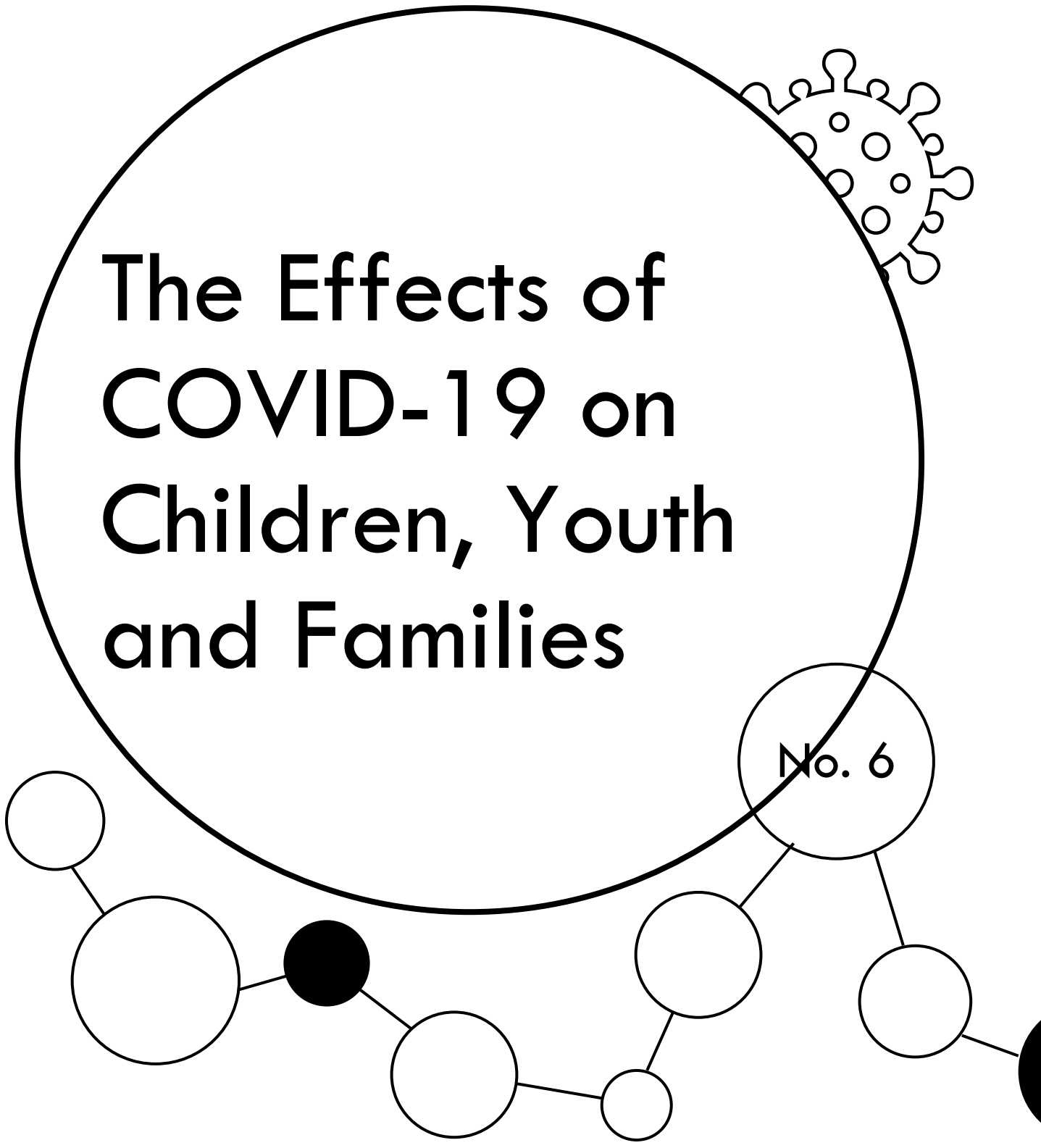
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The Effects of COVID-19 on Children, Youth and Families

No. 6

NASMHPD

Ready to Respond:
Mental Health Beyond Crisis and COVID-19

September 2021

The Effects of COVID-19 on Children, Youth, and Families Across Populations

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***Sixth in the 2021 Ready to Respond Series of Ten Technical Assistance Briefs
focused on Beyond Beds, Reimagining a Sustainable and Robust Continuum of
Psychiatric Care***



National Association of State Mental Health Program Directors

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September 2021

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Recommended Citation:

Rogers, K.M., Johnson, L. & O’Neal, J. (2021). *The Effects of COVID-19 on Children, Youth, and Families Across Populations*. Technical Assistance Collaborative Paper No. 6. Alexandria, VA: National Association of State Mental Health Program Directors.

This work was developed under Task 2.2 of NASMHPD’s Technical Assistance Coalition contract/task order, HHSS283201200021I/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

Abstract:

COVID-19 has had a devastating mental health effect on children and adolescents, who were, prior to the emergence of the Delta variant, largely spared the physical effects of the associated infection. However, more recent data has shown an increase in hospitalizations and the need for medical care while also demonstrating an increase in mental health conditions, including anxiety and depression. Poverty, low educational achievement and other social determinants have further complicated the lives of children and adolescents during this pandemic. The medical and mental health impact of COVID-19 has been more acute in Black, Latinx and Native American communities. The educational system, which serves as a safety net for many youth, has been severely impacted by the pandemic with many schools relying on technology and virtual attendance to educate youth. This has meant that many youth, especially minority youth, have experienced declines in school attendance as many do not have access to computers or broadband to allow them to fully participate. This has resulted in these youth falling three to five months behind academically. There is concern that many of these youth will never overcome these losses. Furthermore, school has been a safe haven. Youth were more likely to experience episodes of domestic violence and abuse without the support and reporting mechanisms that are available when teachers and other school personnel are interacting with youth on a daily basis. These losses place youth at risk for contact with other systems, including juvenile justice and child welfare. It is incumbent upon policymakers to provide adequate support and assist youth in navigating these difficult times.

Highlights:

- COVID-19 has significantly impacted children and adolescent physical and mental health.
- Black, Latinx and Native American youth have been disproportionately affected by the pandemic.
- Poverty and financial inequality have further exacerbated the effects of the pandemic among poor youth.

Recommendations:

1. School systems must think creatively to encourage ongoing learning over the summer. Initiatives might include expanding existing summer-school programs, working with agencies that run summer camps and youth programs so that they add academics to their activities, and enlisting corporations to identify and train volunteer tutors.
2. Health systems must engage with other systems (school, social welfare, and juvenile justice) to educate and encourage youth to engage in behaviors that will prevent COVID-19 infections, but also provide preventive measure to prevent or limit the effects of depression and anxiety.
3. Policymakers should advocate for full funding of social welfare programs for youth and families affected by the pandemic so that there will be an adequate safety net.

Past pandemics, such as the Influenza of 1918, 2009 H1N1 flu, and the 2014 Ebola virus were all associated with increases in depression and anxiety in the population.¹ Like these prior pandemics, COVID-19 has similarly been associated with increased depression and anxiety; however, these mental health issues have been further exacerbated by the social unrest that that has occurred concurrently.² In addition, COVID-19 has impacted people of color disproportionately. Infection case rates, hospitalizations, and death rates among Black, Latinx and Native Americans in the U.S. were two to five times higher than among the white population.³ Further compounding the pandemic stressors among these minority groups are the well-publicized and distressing police murders resulting in emotionally charged national protests and a collective outcry against racism and inequality.

Children and adolescents, for the most part, have largely been spared from the physical consequences of COVID-19. Although the general population child infection and death rates from COVID-19 have remained low over the past year, early findings suggested that Black, Brown and Indigenous children and young adults represented an overwhelming number of the COVID-19-related deaths for those under the age of 21.⁴ However, with each new variant, it appears that the medical risk to children and adolescents appear to be increasing.⁵ This is especially true with the Delta variant that appears to have a higher rate of infectivity than prior variants.⁶

In addition to considering the physical impacts of the virus, much attention has been given to the mental and developmental concerns and risks related to the significant disruption to everyday lives of children and youth. Although pediatric emergency department visits have decreased overall during the pandemic, the number of pediatric emergency department-related visits for mental health concerns have increased.⁷ These trends continue to be called out, with at least one state—Colorado—declaring the gaps in services for youth mental health a “state of emergency” within the overarching disaster of the pandemic.⁸

Many schools struggled to locate many of their students, and concerns about the increase in domestic violence, child trafficking and the health and well-being of America’s children and youth was voiced by many child advocates.⁹ Psychological distress in families has hit unprecedented levels in the United States with 40% of adults struggling with mental health issues by June 2020 during the pandemic.¹⁰ While the full impact on youth is unclear from the current literature, it has been suggested that there are likely long-term repercussions of COVID-19 on children and adolescents.¹¹ The degree to which youth are impacted will depend on vulnerability factors, such as developmental age, pre-existing mental health condition, and socioeconomic status, and other social determinants of health.

The demand for psychiatric acute care beds has also substantially increased.¹² Parents voiced concerns about the inability to provide educational support, limited internet access, the struggles to oversee the educational needs of multiple children on different grade levels and the noted changes in their children’s eating, sleeping patterns and behavior. In 2020, our children were more vulnerable than ever to the chronic stress in the home, the social isolation, involvement in, and awareness of the murders at the hands of the police to people of color, the social unrest and the lack of support, i.e. meals, provided in schools and communities.¹³

The abrupt closing of in-person instruction has, for many across the country, continued well into 2021, significantly hindering children’s social interactions and activities. The transition to online learning came with challenges for many, and the ability of students to effectively work remotely is proving to be

disproportionate across socio-demographic groups. Black youth are more likely to be learning solely online than their white counterparts,¹⁴ which carries a host of immediate and long-term educational gaps and developmental consequences. Although the goals have been to return to in-person learning in the fall of 2021, there remains tremendous anxiety and uncertainty about this plan, especially with mask mandates and other precautions returning by summer of 2021 in the context of the spread of the Delta variant. The disruptions that have occurred by the time of this writing and that will likely continue to be experienced will undoubtedly impact the social, mental, and physical well-being of youth, adolescents and young adults for years to come.

COVID-19 Educational Disparities in Children and Youth

The pandemic has negatively impacted school readiness and has resulted in educational gaps for all students. Youth from Black, Hispanic, and low-income communities have been negatively impacted more than white youth.¹⁵ Many of these youth were already dealing with the loss of loved ones, increasingly difficult financial situations, and parental stress. These situations were worsened as the pandemic has continued. School shutdowns and transition to online learning presented challenges for students from many communities. The United States educational system was not designed to weather the effects of a pandemic such as extended closures, rapid changes in teaching methods with an increase reliance on technology.

When students started school in Fall 2020, on average, they were about three months behind in mathematics.¹⁶ Students of color were about three to five months behind in learning; white students were about one to three months behind.¹⁷ School districts, business leaders and others have suggested plans to address the educational gaps, which if not addressed will translate into wider achievement gaps.¹⁸ Although all students are suffering in various ways, those who came into the pandemic with the fewest academic opportunities are on track to exit with the greatest learning loss.

Beyond access and quality of instruction, students must be in a physical and emotional state that enables them to learn. The COVID-19 pandemic has wreaked havoc on families, leaving many children in precarious and vulnerable situations. Feeding America notes that one in four children is at risk of hunger during the pandemic.¹⁹ Efforts to assist in this area are notable, such as a grant program through the National Farm to School Network that stood as one example of targeting communities disproportionately impacted by COVID-19 and hunger to assist getting fresh food to children.²⁰ The number of children who are housing-insecure has risen as families struggle to pay rent.²¹ Parental supervision and support may be more difficult in families in which both parents need to work outside the home, or in which the parents are English-language learners and cannot directly support their child's learning.

With the COVID-19 pandemic shutting down in-person classes and moving to a virtual learning system, families with children who have intellectual and developmental disabilities (IDD) also experienced a new set of challenges. According to the National Center for Education Statistics, about 14% of all US public school children aged 3-21 received special education services through the Individuals with Disabilities Education Act.²² When schools closed, many families reported a decrease in services offered and some children stopped receiving services at all. In a study by Neece et.al where majority Latinx parents that

had a child with IDD were asked about their pandemic experience, 79.9% of families report that their child's services were decreased.²³

In addition, many families who still received services virtually, just like other school age children, cited issues with the new model of education.²⁴ Virtual learning can be especially difficult for children who are vision or hearing impaired. Prior to the pandemic, students with specific learning disabilities often had specially trained instructors to create their individual education plans. With the sudden changes, parents had to take up the role of educators causing a great deal of stress and many worried that they were not able to meet their child's education needs in addition to balancing work and other responsibilities. This was especially amplified in single parent households and low-socioeconomic status families.²⁵ With the loss of their general support system and normal routines, many of these children began to display an increase in challenging and disruptive behaviors putting further stress on the child and their caretakers. In comparative studies, it was shown that parents of children with IDD were more likely to report increased problematic behavior and mood changes in their children than families with children without disabilities.²⁶ Families also reported that because their child needs were so great, there was significantly more worry about losing income and the care of their child if a caretaker were to get sick or pass away from COVID-19. With reopening after the lockdowns caused by COVID-19, additional work and planning will be needed to make sure these children and their families can transition back to in person classes in the safest and least stressful way. In doing so, it will be helpful for policymakers to learn from what went right and wrong during this pandemic to make sure in the future there are sufficient plans in place, as well as resources, to better support vulnerable families.

Covid-19 Health Disparities in Children and Youth

Since the onset of the coronavirus pandemic, the nation's health inequalities have become even more glaring, with millions of Americans of color, Black and Latino in particular, experiencing more severe illness and death due to COVID-19 than white Americans.²⁷ Yet, relatively few children have died from COVID-19 overall. Only 0.26% of all COVID deaths and less than 1% of COVID hospitalizations are in youth less than 18 years.²⁸ However, children have begun to increase in numbers impacted, and by mid-year 2021, up 21% of new COVID-19 infections are reported in children. This number is likely to rise with the Delta variant growing in prominence in the United States by the summer of 2021 and with plans for school opening to in person learning in Fall 2021.²⁹ Furthermore, recent data from the Centers for Disease Control and Prevention (CDC) reveals that the same racial and ethnic disparities that have affected adults throughout the pandemic, also extend to children of color.³⁰

When it comes to severe illness and deaths from the virus, as noted above, children of color bear a disproportionate burden. Several studies -- and the CDC's database -- reveal that among all children, Black and Hispanic children are more likely to die of the disease.^{31,32} According to 2020 data provided by the CDC, overall at least 423 children and adolescents have died of COVID-19.³³ Latino and Black children currently represent approximately 65% of these deaths. Additionally, children of color are more likely to experience a severe COVID-related inflammatory illness, MIS-C. As of July 31, 2021, 4404 U.S. children have been diagnosed with MIS-C. This rare and extreme immune system response is linked to COVID-19, with 37 MIS-C pediatric deaths according to the C.D.C.³⁴ And at least 63% of reported MIS-C cases have occurred in children who are Hispanic or Latino or Black, non-Hispanic.

The impact of COVID-19 in pediatric populations mirror racial disparities in the adult population. The disproportionately high case rates in Black and Latino children largely reflect how the adults in their lives have been impacted. Affected families are more likely to include essential workers who have had to risk exposures in order to do their jobs. They are also more likely to live in multigenerational homes or more crowded conditions that make distancing or isolating difficult. Communities of color are more likely to experience barriers to high-quality health care and testing, or to face cultural or language challenges in having access to health care. Underlying chronic health conditions that occur in minority youths can adversely affect the course of COVID-19 infection as well.

Social Isolation and Social Media Effects

The COVID 19 pandemic and the associated social isolation for extended periods of time have been linked to worsening mental health.³⁵ Increased loneliness in children and adolescents has been linked to future mental health problems like depression and social anxiety.³⁶ Additionally there has been a worsening of pre-existing conditions such as Attention Deficit Hyperactivity Disorder (ADHD), Post Traumatic Stress Disorder (PTSD), and developmental disorders.³⁷ Much of the early data has caused concern among experts and practitioners that many of these symptoms may lead to chronic symptoms that will affect youth years after the pandemic. Despite the relative lack of data related to the pandemic, the child development literature has shown that prolonged isolation can have a negative effect on child and adolescent development.³⁸ Because peer interaction is such an important developmental factor, the lack of stimulation can lead to cognitive, emotional, and psychological changes in youth. Animal studies have shown that complete social isolation in adolescents resulted in structural changes in the brain and limited peer to peer contact within this developmental stage caused anxiety and reduction of growth in the hippocampus.³⁹ Behaviorally, animal models of social isolation have demonstrated resultant increased aggressiveness, decreased learning and attention, and increased anxiety and depressive symptoms. It is unknown how well the animal studies relate to human development, so more research is needed.

A study by Orben and colleagues demonstrated that social media has had both positive and negative influences on youth during this pandemic.⁴⁰ Technology, such as video chat, has been beneficial in maintaining social connectedness. The use of technology has allowed teens to connect with their peers with some remediation of the effects of social isolation. However, Guessoum, and colleagues have shown that social media, when used passively, can lead to more negative outcomes.⁴¹ Increased reliance on technology places youth at risk for internet addiction, which has been linked to depression. The overuse of social media can also be detrimental as many of these youth are at risk of exposure to cyber bullying which has been shown to have a negative impact on mental health among youth.⁴² Parents vigilance in monitoring the use of the internet, especially in young children, may better protect their safety and mental health. However, many parents, especially parents with limited economic means and social supports, may not be in a position to provide adequate supervision during periods when their younger children are online.

Juvenile Justice Youths and Adults impacted by COVID-19

Individuals impacted by COVID-19 are from populations that have seen their healthcare vulnerabilities exacerbated during the COVID-19 pandemic.⁴³ Those who are incarcerated are among the most vulnerable groups as they frequently do not have the ability to physically distance themselves from others or take other precautions to protect themselves from COVID-19 infection. Until May 2021, youth in juvenile detention facilities did not have access to vaccinations to help prevent illness and spread of disease.⁴⁴

Youth impacted by the juvenile justice system are an important, largely overlooked pediatric population that experienced many of the devastating consequences from COVID-19 that affected other poor and minority youth. COVID-19 among detained youth has been reported in 41 states and the District of Columbia. Cases among staff in juvenile detention facilities have been reported in 43 states and the District of Columbia.⁴⁵ Correctional facilities experienced high likelihood of COVID-19 outbreaks, and disproportionate risk for the 44,000 incarcerated youth, which includes 80% who have a mental health disorder.⁴⁶ Multiple correctional facilities became US epicenters for COVID-19. Incarcerated youth and youth in contact with adults living or working in corrections experienced heightened risk of contracting COVID-19.⁴⁷

The majority of detained youth in the US are poor and from minority groups. They are more likely than white youth to be arrested as juveniles⁴⁸ and are five times more likely than white youth to be incarcerated in juvenile facilities.⁴⁹ The data on COVID-19 and juvenile justice is limited. Rovner has reported that there are at least 1,677 youth in juvenile facilities have tested positive for COVID-19; however, this number is likely higher.⁵⁰

Although it can be easy to forget the plight of youth and adults who are disproportionately in custody, especially during the COVID-19 global crisis, doing so will also threaten the health and well-being of children and their families across the country and the world. Incarceration in the juvenile justice system subjects that youth to additional detrimental experiences, such as solitary confinement, that contribute to negative long-term outcomes.⁵¹ The stress of being in a juvenile justice facility can be an isolating experience. This level of isolation is greatly exacerbated with COVID-19 and places youth at increased risk for negative mental health outcomes. Disruptions, including decreased educational opportunities, a lack of meaningful programming, no physical contact with family members or visits from professionals or their advocates due to the COVID-19 pandemic, can lead to increased loneliness, depression, and anxiety.⁵²

Institutionalized Children and Youth during COVID-19

The pandemic has resulted in closures of schools, decreased employment, and shuttering of faith-based organizations. Local school districts are reporting that there are an increased number of youth who have dropped out of school.⁵³ These factors have been associated with contact with the juvenile justice system.⁵⁴ The reciprocal links between school engagement, youth problem behaviors, and school dropout during adolescence.⁵⁵ The pandemic has caused detention facilities and residential placements to limit the number of youth in confinement care.⁵⁶ The pandemic paused the US school-to-prison pipeline: potential lessons learned.⁵⁷ While the number of youth that are in juvenile detention facilities or other

residential facilities has decreased during the pandemic, the evidence of disproportionate confinement of minority youth became more pronounced.⁵⁸

Youth detention is frequently associated with negative outcomes; however more recent attempts to introduce trauma informed care into detention settings have promise in helping youth navigate the traumas that are antecedents to their detention.⁵⁹ Trauma informed childcare residential placements and hospitals often provide a safe space, while catering to the treatment, educational and basic needs of children and adolescents. Many of the youth that may have benefitted from being in a residential setting have remained in community settings where there is decreased treatment availability and safety net services as a result of the pandemic.⁶⁰

For youth that have been detained during the pandemic, social distancing mandates were enacted and, non-resident staff and family members had to be kept off the premises during the height of the pandemic. The necessity of arranging additional quarantine space for those infected, the supervision of children under physical mandated distancing policies with limited staff aggravated the system of care needed to support the confined youth and address this crisis. This social isolation has understandably resulted in increased anxiety and depression in detained youth.⁶¹

Although much of the mental health continuum of care for youth is moving towards maintaining youth in their natural home environments, given the myriad of challenges facing youth, residential placements have also been in demand. As such, capacity building is needed to effectively manage the need for an array of mental health services to handle the crisis. Relaxing the eligibility for admissions to adequately address the crisis experienced by families and community members could offer another approach to providing access to needed supports.

Financial Inequalities Impacting Youth and their Families During COVID-19

Loss in income, employment, and food security can have both direct and indirect negative effects on children. Family instability, such as that produced by sudden unemployment, can affect children's social-emotional, cognitive, and academic outcomes. Furthermore, children who experience sustained poverty are more likely to drop out of high school, have irregular employment, and experience poverty as adults.⁶²

Families living in households where the rent or mortgage payment was late and where there was not enough food have struggled during this pandemic. At the national level, the Household Pulse Survey Phase 1 data (April 23, 2020-July 1, 2020) indicated that about 11.8 million children live in households that missed a mortgage or rent payment or sought a deferment, while roughly 3.9 million children were experiencing COVID-19 induced food shortages.⁶³ However, these groups include substantial overlap — nearly 1.3 million children live in households facing both food and housing types of insecurities.

In preparation of future pandemics, narrowing existing equity gaps is critical to ensuring a path to a more equitable future that promotes shared prosperity, health and well-being for all. There are policies and programs that point the way forward, both in the short and long term. In addition to the funds made available through the Coronavirus Aid, Relief, and Economic Security Act, Policymakers can also consider steps to reduce the pandemic's economic effects, such as increasing protection and pay for essential workers, supporting efforts to stabilize renters, improving access to refinancing for

homeowners, and establishing a federal jobs program to get people back to work and prevent extended periods of unemployment and food insecurity for those disproportionately impacted such as families of color.

Telemedicine, COVID-19 and Impact on Youth

As recently as February 2020, before the current pandemic was declared, there was evidence supporting teen interest in and acceptance of receiving primary healthcare virtually. The work by Sequeira et. al suggests that many gender-diverse youth were open to using telehealth to receive gender-affirming care and were particularly interested in doing so for ongoing care (such as for laboratory monitoring and medication refills).⁶⁴ A potential benefit of virtual visits for children and adolescents includes the ability to avoid stigmatized reactions and receive confidential services without alerting caregivers because of travel needs.

As adolescents embrace the use of telemedicine during the COVID-19 pandemic, we must continue to work to ensure that care is available as widely as possible. This includes decreasing barriers to care including lack of broadband connectivity, lack of equipment, limited knowledge of the technology needed to connect, and lack of access to providers offering telemedicine. Ideas for future telemedicine uses include increasing school-based telehealth services, partnering with community agencies to help reach youth who are homeless or involved in the juvenile justice system. Focus on rural areas and provider shortage locations is critical to decreasing the inequalities of health care. One area of significant concern is the access to confidential services (reproductive health, contraception, mental health, addiction services, and medicine) that may be otherwise difficult to access.

Policy makers and funders should also consider how to develop care teams that incorporate telemedicine even though providers may work remotely, and team members may not in the same physical location. More research is needed on health care delivery to adolescents and young adults using technology-based solutions.

Guidelines must be developed on how to involve learners in care and teach the future adolescent health providers how to think creatively about solutions for reaching youth without compromising safety elements in care delivery, such as suicide risk assessment and management. One thing is certain moving forward, now that patients and providers have experienced digital technology for health care, school, and social connection, technological innovation in healthcare is here to stay and likely increase. Over time, specific methodologies and research analytics will help drive shifts in how telemedicine is delivered for continuous quality improvement.

Recommendations to strengthen youth and families in the context of COVID-19*

1. Ensure that race and equity are primary considerations as policies are developed.
2. Ensure that physical and mental health is prioritized across all youth
3. Assist youth and families with economic stability and recognize its importance in emotional well-being
4. Advocate for equivalent and adequate funding for schools to meet the needs of all youth including those disproportionately impacted by the pandemic.

*Adapted from recommendations by The Annie E. Casey Foundation

<https://www.aecf.org/blog/new-report-finds-many-families-with-children-are-depressed-uninsured-hungry>. December 14, 2020

Confidentiality will continue to be a cornerstone of adolescent visits. When using telemedicine, top priorities of the health care teams will include ensuring the virtual environment is established to be private as well as safe. This is particularly challenging when the youth is meeting with a provider or a care team from home, given the often-crowded living environment for youth of color and those in crowded urban settings with multi-generational families residing in small residential settings. In the office setting, family members and other caregivers are asked to leave the examination room, so the provider and adolescent can speak freely. This may not be feasible when providing care to a patient at home, so youth may need to be asked to move to a more private location (if available), use a headset, or use the chat feature of the video conference tool to obtain and share confidential information.

Screening for mental health may require providers to send documents via email or utilize an electronic health record ahead of scheduled encounters. This pre-visit screening necessitates the need for safety protocols to address acute concerns (such as suicidality or disclosed abuse) outside of the telemedicine encounter.

Despite challenges, providers saw patients using telemedicine during the pandemic⁶⁵ and there is growing evidence that telemedicine is feasible for providing care to youth for a variety of health concerns, including contraception, gender-affirming care, behavioral health, substance use, eating disorder treatment, and for continuing the clinical education of future leaders in adolescent health.

Conclusion

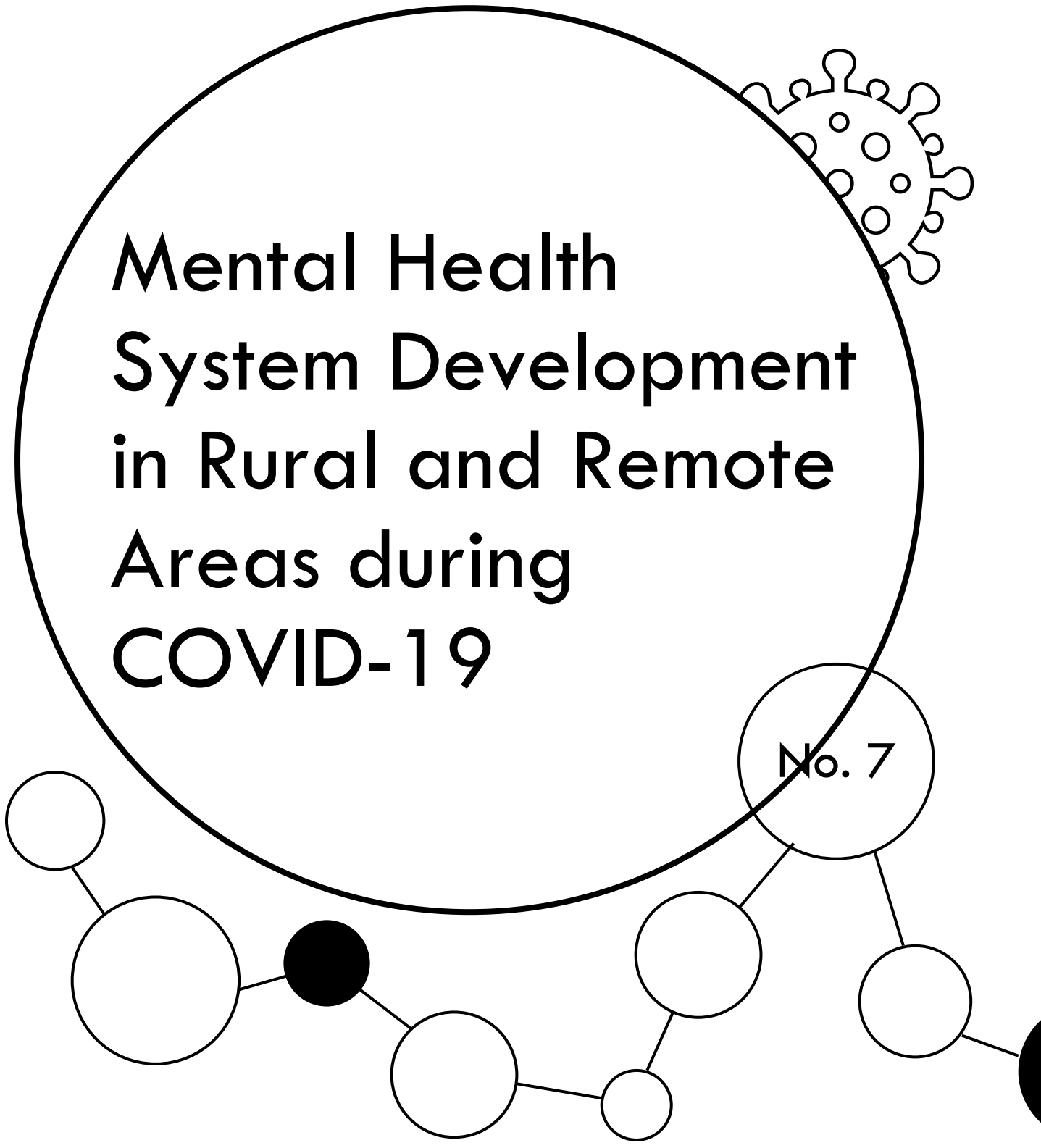
More than one year after the death and trauma of so many who succumbed to COVID-19, where are we now and what must we do to ensure families, children and communities can move to a state of health and wellness? With the toll of Covid-19 hopefully soon more on our heels, how do we begin to address racial disparities among children, and families which could impact their health and well-being today as well as later in life? The pandemic's impact has yet to be fully realized as states continue to struggle to move beyond the crisis and as the virus continues to evolve. As stated earlier, pandemics of the past have always left many young people experiencing anxiety and depression and in need of services and supports. How do we meet the needs of those whose mental health challenges have been exasperated by the pandemic-- all while engaging families who have never received services for their children? Much has been realized with regard to priorities and needs, including: the need to improve the mental health care provided for children, adolescents and their families; the need to embrace a workforce of professionals to provide the continuity that children, especially children and adolescents struggling with anxiety, deserve; and last but not least, the need to build trust during numerous events of highly publicized racial injustices. Put simply, the COVID-19 pandemic has brought racial/ethnic disparities in health, education, the justice system, income, into plain sight, and this has been alarmingly apparent for adults, as well as for children. We can and we must improve the inequities that plague our country. Now more than ever silos need to fall, family's voices should be heard, and faith-based organizations need to be acknowledged and embraced as a resource to provide care in many communities of color, while local community leaders are more embraced and supported. We need systems of care and these systems must be energized to focus on youth who hold the promise of tomorrow.

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Mental Health System Development in Rural and Remote Areas during COVID-19

No. 7

NASMHPD

Ready to Respond:
Mental Health Beyond Crisis and COVID-19

September 2021

Mental Health System Development in Rural and Remote Areas during COVID-19

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***Seventh in the 2021 Ready to Respond Series of Ten Technical Assistance Briefs
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Psychiatric Care***



National Association of State Mental Health Program Directors

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September 2021

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Recommended Citation:

de Voursney, D., Arienti, F., Martone, K. (2021). *Mental Health System Development in Rural and Remote Areas during COVID-19*. Technical Assistance Collaborative Paper No. 7. Alexandria, VA: National Association of State Mental Health Program Directors.

This work was developed under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS283201200021I/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

Abstract:

Mental health service barriers in rural and remote areas, including unmet need, lack of access to services, and insufficient workforce capacity have been exacerbated by the COVID-19 pandemic. These factors also impact tribal governments and American Indian and Alaska Native (AI/AN) populations living in rural and remote areas, which face additional obstacles in mental health service delivery, but also have unique cultural and programmatic assets. An existing body of work explores problems and solutions faced in the delivery of mental health services in rural, remote, and tribal areas. This paper summarizes some of this work and explores the context of COVID-19. In addition to a review of the literature, the paper draws on national survey data and interviews with experts. The paper examines rural and remote mental health systems during the pandemic within the “Beyond Beds” framework, assuming a goal of creating a robust, interconnected, and evidence-based system of care. Rural and remote populations have experienced increased prevalence of mental illness a result of COVID-19, but the complete impact of the pandemic on mental health and social wellbeing remains unknown. Rural and remote mental health systems experienced disruptions to service delivery and rapid adoption of tele-behavioral health during the pandemic. While this natural experiment demonstrated the value of increased tele-behavioral health care, additional work remains to understand the optimal role of telehealth in rural and remote mental health systems.

Highlights:

- Rates of mental disorders are generally similar across rural and non-rural areas and the substantial negative impacts of COVID-19 on mental health seem also to be similar
- Overall rates of mental health care receipt are not largely different across rural areas and other areas, but access to specialty and intensive care is lower in rural areas.
- Rural areas continue to face mental health workforce shortages, which may be addressed using a range of approaches.
- More work remains to develop and adapt mental health care models for rural and remote areas, including models that are effective for AI/AN communities.
- COVID-19 led to a massive natural experiment in the rapid and widespread implementation of tele-behavioral health care.

Recommendations for the Post-COVID-19 Future:

1. Policymakers should try to learn from experiences during the pandemic to develop systems that encourage the appropriate role for telehealth, without reflexively reverting to the pre-pandemic status quo.
2. Developing the rural mental health workforce should be a continued priority. Efforts to train and recruit mental health professionals in rural and remote areas should be combined with service adaptations and supports like remote consultation to fully leverage existing workforce capacity.
3. There should be a more concerted effort to examine behavioral health surveillance, facility, and claims data by urbanicity, including stratification of data from more remote areas, to understand the impact of COVID-19 on systems and people in rural and remote areas.
4. There is a need for service model innovation and adaptation in rural and remote areas, especially to meet the needs of people with intensive and complex mental health needs. This work should be attentive to different population groups, including AI/AN populations.

Nearly one in five Americans lives in a rural or remote^a area.¹ People in these areas experience mental disorders at similar rates to people in urban and suburban areas but face barriers to accessing needed care.² The COVID-19 pandemic has exacerbated challenges in access and delivery of mental health services in rural and remote areas, including transportation, high poverty rates, and insufficient workforce capacity. Tribal mental health systems and American Indian and Alaska Native (AI/AN) populations living in rural and remote areas, who face greater behavioral health challenges than other population groups,³ have unique programmatic and cultural assets that can be learned from to address challenges associated with mental health care access in rural or remote areas.

This review, *Mental Health System Development in Rural and Remote Areas During COVID-19*, explores problems and solutions faced in the delivery of mental health services in rural, remote, and tribal areas in the context of COVID-19. People living in rural and remote areas, including AI/AN individuals and communities, are best served by a robust, interconnected, and evidence-based system of mental health care, such as that presented in the *Beyond Beds* framework.⁴ With this as the goal, this paper attempts to examine the current state of mental health care in rural and remote areas and propose strategies for building a better system for the future.

Mental Health System Development in Rural and Remote Areas during COVID-19 will address the following areas related to rural mental health systems as it is and areas of needed development.

- The impact of COVID-19
- Prevalence of mental illness and related problems
- Access to treatment and specialty care
- Workforce challenges in rural and remote areas
- The unique needs of AI/AN communities
- Telehealth services
- Building the array of effective practices in rural and remote settings
- Developing rural crisis systems

Although this paper will discuss rural and remote areas generally, rural and remote areas across the United States are varied in terms of their populations, geography, and the mental health systems that serve them. Rural areas span all regions across the continental United States as well as Alaska and Hawaii. There are also rural areas in U.S. territories like Puerto Rico. Rural demographics also vary considerably. In many rural areas, there are significant American Indian, Alaska Native, or Pacific Islander populations. Some rural areas have sizable populations of migrant workers and Latino populations, others have large black or African American populations, such as rural areas in the south, whereas others are predominately white.

As with the rest of the country, rural areas are also varied in terms of the mental health and substance use disorder systems that serve them. Different states provide different health, behavioral health, and human service arrays through Medicaid and their public systems. Some states have county and regionally driven systems which means that there can be significant variability in mental health and

^a In this paper we have decided to use the term remote instead of frontier. Frontier comes with the connotation that these areas are left to be explored and even exploited. We use the term remote to avoid this connotation and to recognize that people have lived in these areas for millennia.

substance use disorder systems within states. States also vary in terms of the groups that are eligible for Medicaid and other state provided supports, which can lead to differences in access to care.

The Impact of COVID-19

The COVID-19 pandemic has had dramatic impacts across the United States, disrupting work, school, social interaction, and economic activity. Not surprisingly, these disruptions have had wide ranging impacts on mental health at the same time as disrupting mental health service delivery.⁵ Initially, death rates from COVID-19 were higher in urban areas, but by Summer 2020, rural rates of COVID-19 deaths had surpassed urban areas.⁶ Now, urban populations are being vaccinated at higher rates than rural populations,⁷ which may result in higher levels of spread in impact in rural areas going forward compared with urban areas.

There has been a marked increase in mental health problems in the United States due to COVID-19. According to a June 2020, Center for Disease Control and Prevention (CDC) survey:⁸

- 31% of respondents reported symptoms of anxiety or depression, an increase from 11.0 percent in January through June of 2019.
- 13% of people reported that they had started or increased substance use to cope with pandemic related stress or emotions.
- 11% of respondents reported serious consideration of suicide in the previous 30 days, compared with 4.3% in a similar 2018 survey.

There were not statistically significant differences in outcomes reported between urban and rural respondents, though at the time of the survey, people in rural areas reported fairing slightly better on average compared to urban counterparts across the items being measured.⁹ Later in the pandemic, the CDC reported national data collected between August 2020 and February 2021 which indicated that the percentage of adults experiencing symptoms of anxiety or depression increased from 36% to 42% without breaking out data for rural areas.¹⁰ A survey of rural adults in December 2020 echoed these findings: 56% of rural adults said that they were personally experiencing more mental health challenges than a year ago. 53% of the respondents said that that COVID-19 had impacted their individual mental health “some” or “a lot,” and 61% said the same about the mental health impact in their communities.¹¹ In general mental health across the country seemed to decline as the pandemic continued. Current data does not seem to indicate large differences in impact in mental health across rural and non-rural areas, but a more detailed understanding may be possible as more data becomes available.

In addition to impacting the mental health of people in the United States, COVID-19 has also disrupted access to mental health services. Comparing the period from March to October 2020 with the same period in 2019, there were approximately one-third fewer Medicaid or Children’s Health Insurance Program claims for mental health services for children and one-fifth fewer mental health claims for adults.¹² Given that mental health needs increased during the pandemic, this means that many people did not receive needed care. In 2019, 11% of children 12 years and older who accessed mental health services did so through schools.¹³ School closures potentially disrupted these supports in both rural and non-rural areas, which may have further reduced access to care for young people.

The COVID-19 pandemic has presented additional challenges to providers trying to deliver mental health services in rural areas. Rural behavioral health systems were already stressed by the alarming growth of opioid use and overdose deaths over the past two decades, and early evidence suggests that the COVID-

19 pandemic has exacerbated the opioid crisis.¹⁴ Rural and remote areas already faced mental health service staffing challenges, and like other areas, were impacted by lack of personal protective equipment (PPE) and child care as schools halted in-person learning. Provider organizations had to manage the shift to delivering services virtually where possible and work to develop feasible business models in the COVID-19 context. The in-person service delivery that was central to most providers' operations prior to the pandemic was no longer feasible and they were forced to adapt in order to continue generating needed revenue and delivering services. As Dennis Mohatt, Vice President for Behavioral Health and Co-Director of the Mental Health Technology Transfer Center at the Western Interstate Commission for Higher Education put it, "Delivering treatment, prevention, and support in rural and remote places is a difficult thing on a good day, and it hasn't been a great day for a while."¹⁵

Prevalence of mental illness and related problems

Before the pandemic, overall rates of mental illness and treatment receipt were similar across large metropolitan counties, small metropolitan counties and non-metropolitan counties. According to data from the Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health, in 2019, among people 18 years and older in non-metropolitan counties, 21.2% met criteria for having any mental illness (AMI), 5.9 percent met criteria for having a serious mental illness (SMI), 7.0 percent met criteria for having a substance use disorder (SUD) and 3.6 percent met criteria for having a mental illness and a co-occurring SUD. This is similar to national rates for AMI (20.6 percent), SMI (5.2 percent), SUD (7.7 percent) and co-occurring AMI and SUD (3.8 percent).¹⁶

Large metropolitan counties: contain cities with a population larger than 1 million people.

Small metropolitan counties: contain cities with populations between 50,000 and 1 million people.

Non-metropolitan counties: contain cities with populations no larger than 50,000 people. This is used to identify rural areas by many surveys and government systems.

In 2018, rural areas experienced a higher suicide rate in than urban areas with 19.1 deaths by suicide per 100,000 people compared with 13.4 per 100,000 in urban areas. The suicide rate in rural areas increased 48% from 2000 to 2018.¹⁷ There are a number of factors that may contribute to higher suicide rates in rural areas including economic disparities, the larger presence of subpopulations that experience higher suicide rates, including AI/AN people and non-Hispanic white males, and higher rates of gun ownership, which are associated with increased risk of suicide.¹⁸ While there is not a clear reason for increases in the suicide rate, one leading theory is that they have been driven up as a part of general increase in "deaths of despair" resulting from problems in labor markets, educational attainment, marriage and family outcomes, and physical health.¹⁹

Access to treatment and specialty care

Before COVID-19, total rates of past year mental health service use were similar across rural and non-rural areas. According to 2019 National Survey on Drug Use and Health (NSDUH) data:

- 46.5% of people with AMI in non-metropolitan counties received mental health services in the past year compared with 43.6% in large metropolitan and 46.0% in small metropolitan counties.
- 65.7% of people with SMI in non-metropolitan counties received mental health services compared with 65.9% in large metro and 64.9% in small metropolitan areas.²⁰

However, patterns of mental health treatment receipt across rural and urban counties differ by type of treatment received. Data from 2010 to 2019 prior to COVID-19 showed that people in non-metropolitan counties were significantly less likely to receive outpatient treatment than individuals in large or small metropolitan counties and significantly more likely than people in large metropolitan areas to receive prescription medication without other forms of treatment (see Table 1 for details).

Table 1: Past Year Mental Health Treatment Receipt by County Metropolitan Status (2010-2019)

County Metropolitan Status	Total	Any Mental Health Treatment	Any Inpatient Treatment*	Any Outpatient Treatment	Only Outpatient Treatment	Only Received Prescription Medication	Only Received Outpatient Treatment and Prescription Medication	Received Inpatient and Outpatient Treatment and Prescription Medication	
Total	<i>Number</i>	239,574,000	35,034,000	2,135,000	17,202,000	4,993,000	16,911,000	10,855,000	997,000
	<i>Percent</i>	100.00%	14.60%	0.90%	6.50%	2.10%	7.10%	4.50%	0.40%
	<i>95% CI</i>	N/A	(14.50% - 14.80%)	(0.80% - 0.90%)	(6.40% - 6.60%)	(2.00% - 2.10%)	(6.90% - 7.20%)	(4.40% - 4.60%)	(0.40% - 0.40%)
Large Metro	<i>Number</i>	129,695,000	18,031,000	1,111,000	9,436,000	3,022,000	8,098,000	5,721,000	502,000
	<i>Percent</i>	100.00%	13.90%	0.90%	6.60%	2.30%	6.20%	4.40%	0.40%
	<i>95% CI</i>	N/A	(13.70% - 14.10%)	(0.80% - 0.90%)	(6.40% - 6.70%)	(2.20% - 2.40%)	(6.10% - 6.40%)	(4.30% - 4.50%)	(0.40% - 0.40%)
Small Metro	<i>Number</i>	72,012,000	11,383,000	653,000	5,412,000	1,428,000	5,718,000	3,550,000	330,000
	<i>Percent</i>	100.00%	15.80%	0.90%	6.80%	2.00%	7.90%	4.90%	0.50%
	<i>95% CI</i>	N/A	(15.50% - 16.10%)	(0.80% - 1.00%)	(6.60% - 7.00%)	(1.90% - 2.10%)	(7.70% - 8.10%)	(4.80% - 5.10%)	(0.40% - 0.50%)
Non-Metro	<i>Number</i>	37,867,000	5,620,000	371,000	2,354,000	543,000	3,094,000	1,585,000	165,000
	<i>Percent</i>	100.00%	14.80%	1.00%	5.60%	1.40%	8.20%	4.20%	0.40%
	<i>95% CI</i>	N/A	(14.50% - 15.20%)**	(0.90% - 1.10%)	(5.40% - 5.80%)**	(1.30% - 1.50%)**	(7.90% - 8.50%)**	(4.00% - 4.40%)	(0.40% - 0.50%)

Table populated using National Survey on Drug Use and Health: 10-Year Substate Restricted-use Data Analysis System (2010 to 2019) – using the following variables (COUTYP2, AMHSVTY, AUOPTYR, AMHTXRC3, AMHTXRC3, AUINPYR)
 * AUINPYR is not restricted to adults, youth 12-17 were excluded using CATAG18 as a control variable.
 ** Non- Metropolitan Area result is statistically different from Large Metropolitan Area and Small Metropolitan Area results at the .05 level
 *** Non- Metropolitan Area result is statistically different from Large Metropolitan Area results at the .05 level.

While these numbers point to similar rates of treatment receipt across rural and urban areas, there are some important caveats. These data do not capture differences between people in more populous rural areas and people in remote areas. There may be more clear disparities in access to mental health services between metropolitan areas and more remote areas. These data also do not include information about the frequency of treatment receipt. It is possible that people in rural areas exhibit similar rates of treatment overall, but access treatment at lower frequency because of access barriers.

These data also do not capture access to more specialized forms of mental health treatment and services, which people in rural areas are less likely to have access to. Compared to urban areas, people in rural areas are much more likely to seek mental health care through primary care. According to data from 2012–2014 National Ambulatory Medical Care Survey, 29% of physician office visits related to mental health in non-metropolitan areas were made to psychiatrists and 54% were made to primary care physicians, compared to 55% and 32% nationally.²¹ This lack of access to specialized services for rural areas extends to other service systems. Veterans who have received mental health services from

the Veterans Health Administration are much less likely to receive specialized care, including care for SMI, in rural areas.²² An examination of one state system showed that evidence-based programs (EBPs), such as Assertive Community Treatment (ACT), Supported Employment, Supportive Housing, and Multisystemic Therapy, were less likely to be offered in rural areas and staff in rural areas were less likely to be trained in EBPs in rural areas compared with urban areas.²³

If the goal is to develop a robust system of care of quality treatment and services in rural and remote areas before, during, and after acute episodes of mental illness in keeping with the *Beyond Beds framework*,²⁴ we must look beyond rates of treatment receipt to examine more specialized supports and services. This is particularly true for adults with SMI and Children with Serious Emotional Disturbances (SED) who are dependent on public systems and will need access to more specialized and intensive supports to facilitate their recovery.

Prior to COVID-19, there were minor differences in the reasons given for not getting treatment by people in rural areas compared with more urban areas, according to the NSDUH (Table 2). People in rural areas were more likely to report cost as a reason for not seeking treatment compared with people in large metropolitan areas. Conversely, people in rural areas were less likely to report that they did not know where to go for services or that they didn't feel that they needed services compared with people in large metropolitan areas. They were also less likely to report that they did not have time to access services compared with people in large or small metropolitan areas. Rural Americans were not significantly more concerned about negative opinions by friends and neighbors or impacts on their job than people in other areas but were more concerned about confidential information being shared by providers than people in large metropolitan areas. Interestingly, they were more likely to report that having no transportation, treatment being too far away, or the hours not being convenient as a reason for not seeking treatment compared to people in large urban areas, but not significantly more likely to report this as a reason for not seeking treatment than people in small metropolitan areas. Together, these results indicate that reasons for not getting treatment are similar across metropolitan and non-metropolitan areas. This seems to indicate that attitudinal barriers and even transportation are not driving large disparities in access in rural non-metropolitan areas in general.

Table 2: Reasons Given for Not Getting Treatment that Was Felt to Be Needed in Past Year by County Metropolitan Status (2010-2019)

Reason	Large Metro	Small Metro	Non-metro
Could not afford cost	41.40% (40.30% - 42.60%)	44.20% (42.80% - 45.60%)	44.90% (42.90% - 47.00%)*
Concerned about neighbors or community negative opinion	9.40% (8.70% - 10.00%)	9.80% (9.10% - 10.50%)	10.00% (9.00% - 11.10%)
Concerned about negative effect on job	8.60% (8.00% - 9.30%)	8.20% (7.50% - 8.90%)	8.90% (7.90% - 10.00%)
Health insurance does not cover any mental health treatment or counseling	6.90% (6.30% - 7.50%)	7.10% (6.50% - 7.80%)	6.10% (5.30% - 7.10%)
Health insurance does not pay enough for mental health treatment or counseling	13.90% (13.10% - 14.80%)	13.10% (12.10% - 14.10%)	10.90% (9.70% - 12.30%)*
Did not know where to go to get services	22.60% (21.60% - 23.50%)	20.10% (19.00% - 21.10%)	18.40% (17.00% - 19.80%)*
Concerned information given to counselors might not be kept confidential	7.90% (7.30% - 8.60%)	8.20% (7.60% - 8.90%)	10.00% (8.90% - 11.20%)*
Concerned that you might be committed to a psychiatric hospital or might have to take medicine	10.30% (9.70% - 11.00%)	11.00% (10.30% - 11.80%)	11.20% (10.10% - 12.40%)
Didn't think you needed treatment at the time	9.60% (9.00% - 10.30%)	9.40% (8.60% - 10.20%)	7.70% (6.80% - 8.60%)*

Reason	Large Metro	Small Metro	Non-metro
Thought you could handle the problem without treatment	26.50% (25.50% - 27.60%)	25.80% (24.60% - 27.00%)	24.10% (22.50% - 25.80%)
Didn't think treatment would help	10.30% (9.60% - 11.10%)	10.40% (9.60% - 11.20%)	9.30% (8.20% - 10.40%)
Didn't have time (because of job, childcare, or other commitments)	18.70% (17.80% - 19.60%)	17.80% (16.80% - 18.80%)	14.20% (13.00% - 15.50%)**
Didn't want others to find out that you needed treatment	6.70% (6.10% - 7.20%)	7.20% (6.60% - 7.80%)	6.90% (6.10% - 7.80%)
Had no transportation, or treatment was too far away, or the hours were not convenient	4.20% (3.80% - 4.60%)	4.50% (4.00% - 5.00%)	5.70% (4.80% - 6.70%)*
Table populated using National Survey on Drug Use and Health: 10-Year Substate Restricted-use Data Analysis System (2010 to 2019) – using the following variables (COUTYP2, MHRCOST2, MHRNBR2, MHRJOB2, MHRNCOV2, MHRNUF2, MHRWHER2, MHRCFID2, MHRCMIT2, MHRNOND2, MHRHAND2, MHRNOHP2, MHRTIME2, MHRFOUT2, and MHRTRAN)			
* Non- Metropolitan Area result is statistically different from Large Metropolitan Area results at the .05 level.			
** Non- Metropolitan Area result is statistically different from Large Metropolitan Area and Small Metropolitan Area results at the .05 level			

Workforce Challenges in Rural and Remote Areas

Rural and remote areas have widespread shortages of mental health professionals. More than 25 million people in rural areas, almost half the rural population, live in Health Resources and Services Administration (HRSA) designated mental health professional shortage areas.²⁵ Data from the National Plan and Provider Enumeration System shows that 65% of non-metropolitan counties do not have a psychiatrist and 47% do not have a psychologist.²⁶ Non-metropolitan areas on average have 5.8 psychiatrists and 13.7 psychologists per 100,000 people compared with 17.5 psychiatrists and 33.2 psychologists per 100,000 people in metropolitan areas. Behavioral health provider supply was even more limited in more remote non-metropolitan counties without any small cities or towns, 80 percent of these counties lacked a psychiatrist and 61 percent lacked a psychologist.²⁷ Specialized care is also less available in rural areas. People in urban areas have access, on a per capita basis, to 3.5 times as many child and adolescent psychiatrists, five times as many geriatric psychiatrists, and almost five times as many addiction psychiatrists.²⁸

Building the rural mental health workforce will require a variety of strategies, such as providing financial incentives,²⁹ providing training and supervision necessary for licensure³⁰ and active recruiting and retention efforts.³¹ Strategies for developing workforce capacity in rural areas includes adapting service delivery models because the most specialized and credentialed providers are less likely to be available in rural and remote areas. Mental health providers in rural and remote areas may have to adapt service models to rely more on providers with less credentials, including peer providers.

Task sharing or shifting tasks from more trained to less trained or specialized individuals is one approach to increasing capacity in underserved areas. Task sharing can leverage consultation with specialists to support service provision, such as expanding the capability of primary care to provide behavioral health services through the Collaborative Care Model.³² As noted earlier, people in rural areas are more likely to get behavioral health care from primary care providers. Although these providers may be comfortable treating more common mental disorders like anxiety and depression, they are less comfortable providing treatment for conditions like schizophrenia and bipolar disorder.³³ Primary care providers also are unlikely to have the capacity to coordinate care for individuals with SMI that are facing challenges with social determinants of health, such as housing or employment challenges. Task sharing may be used to free up mental health specialist resources so that they can serve people with more complex or

intensive needs. Telehealth is another strategy for improving access, which is discussed in more detail below.

COVID-19 has disrupted the business models and operations of mental health care providers leading to additional stressors for mental health care workers. For many mental health workers, shifting to telehealth platforms led to new forms of stress and compassion fatigue, while they concurrently struggled with disruptions to their personal lives that impacted everyone during the pandemic.³⁴ In the near term, mental health systems, including those in rural and remote areas, will need to manage the shift to telehealth, support employees through pandemic related stressors, and shift business models to adapt to new ways of delivering services.³⁵ The extent to which the shift to telehealth is a permanent change remains to be seen. The number of people who will seek care as public health measures relax, and the demand they will place on mental health systems is also unknown. Mental health systems will have to monitor and adapt, being mindful of the impact on their workforce.

Meeting the unique needs of AI/AN communities

AI/AN people come from diverse backgrounds and live in urban, rural, and remote areas across the United States: 40% of AI/AN people live in non-metropolitan areas and 22% live on reservations or other trust lands.³⁶ AI/AN people also come from distinct tribal backgrounds. 574 sovereign tribal nations have a formal nation-to-nation relationship with the federal government and there are 334 reservations across 35 states.³⁷

As of April 2021, AI/AN people in the United States experienced the highest death rate from COVID-19 compared with other racial and ethnic groups and were 2.4 times as likely to die from COVID-19 compared with whites.³⁸ Recognizing this tragic truth, the pandemic also demonstrated tribal public health capacity. Many tribes were able to institute innovative and forward leaning public health measures³⁹ and have also led in vaccine distribution, initially achieving higher rates of vaccination than other racial and ethnic groups.⁴⁰

In 2019, among AI/AN people 18 and older, 23.6% met criteria for having AMI, 7.2% met criteria for having SMI, 8.9% of met criteria for SUD, and 4.7% met criteria for having AMI and a co-occurring SUD. For each of these conditions, AI/AN individuals experience higher rates than national averages across racial and ethnic groups. Nationally, AI/AN individuals 18 years and older were less likely to receive mental health services (13.9 %) compared with the national rate (16.1 percent).⁴¹ AI/AN people also had the highest rate of suicide among racial and ethnic groups in 2019, at 22.5 per 100,000 compared with a national rate of 13.9 per 100,000.⁴²

Mental health services for tribal communities often are provided by a mix of Indian Health Service (IHS), Tribal, county, state, and nonprofit organizations. In addition to the services and systems available to the general population, members of tribes living on or near reservations can receive services funded through the IHS. As of 2019, IHS served 2.6 million people across 37 states.⁴³ In rural areas, this care is delivered through IHS facilities or through tribally operated facilities. Tribes that receive care through IHS are referred to as *direct service tribes* and tribes that manage their own health systems are referred to as *self-governance tribes*. These programs provide primary care and community health services, including behavioral health care through 568 facilities, including hospitals, health centers, health stations, Alaska village clinics, school health centers, and youth regional treatment centers. The availability of services varies across service units and locations. Specialty services and types of care that

are not available at these facilities can be purchased from private providers through the IHS purchased/referred care program, but this funding is limited.^{44,45}

Tribal communities in rural and remote areas often are built around distinct sovereign tribal nations with unique needs and cultures. As a result, it is necessary to develop solutions that are specific to the context of each tribal community, that respond to the needs identified by that community and use practices that are chosen by and acceptable to that community. A number of strategies hold promise in the development of tribal mental health systems, such as developing a culturally competent and responsive workforce; adopting culturally adapted treatment approaches; integrating traditional practices into behavioral health supports; and using the traditional strengths embodied in tribal communities as a part of support systems for people with mental or substance use disorders.⁴⁶ Given the shortage of culturally informed mental health workers in tribal communities, a natural solution is to recruit and train AI/AN individuals to become part of the behavioral health workforce. As with other rural and remote areas, task sharing with lower credentialed workers is another promising strategy,⁴⁷ exemplified by the Behavioral Health Aides who serve tribal communities in Alaska. These individuals are supervised by licensed clinicians and provide a variety of therapeutic supports, including connecting people to higher levels of care when needed.⁴⁸

State and local mental health systems working with tribal communities need to respect the tribal independent status as they work collaboratively to ensure that the mental health needs of tribal community members are being met. As noted, IHS and tribal systems provide important mental health services including outpatient mental health counseling, access to dual diagnosis services, mental health crisis response and triage, case management, community-based prevention programming, and outreach and health education activities.⁴⁹ Yet, as with almost all local rural and remote behavioral health systems at the community level, tribal mental health systems are unlikely to provide all needed services, such as inpatient care, or intensive coordinated services for individuals with SMI. In fact, as of 2011, no IHS facilities provided inpatient psychiatric services.⁵⁰

Building the capacity to serve members of tribes in a culturally responsive manner in collaboration with tribal mental health systems is the responsibility of non-tribal public mental health systems, just as it is for the services they provide to any individual in their service area. Providers and clinicians working within these systems should receive training in cultural humility and these principles and practices should be integrated into service delivery for AI/AN individuals. SAMHSA provides useful resources such as its Culture Card, designed to enhance cultural competence when serving AI/AN individuals, which specifically suggests that training be provided by a member of the particular AI/AN community being served.⁵¹ SAMHSA's Tribal Training and Technical Assistance (TTA) Center, sponsored by the Office of Tribal Affairs and Policy (OTAP), is another good resource for culturally relevant training and technical assistance to support mental health in tribal communities (<https://www.samhsa.gov/tribal-ttac>). State and local mental health systems should consult and work with tribal behavioral health systems to provide an effective continuum of supports for AI/AN individuals, particularly people with more complex or intensive needs. As these individuals may move in and out of tribal systems to access inpatient care and other supports, coordination is especially important across systems to ensure that individuals do not become disconnected or have their care and support networks disrupted during transitions. Tribal systems will likely face some of the same challenges following COVID-19 as other rural and remote systems, determining the appropriate role for telehealth, and trying to address pent up demand for services from people who did not seek help during the COVID-19 pandemic. Tribal systems and their state and local partners will need to adapt to conditions as they unfold.

Telehealth Services

The most pervasive change in mental health service delivery during the COVID-19 pandemic has been the shift to telehealth. The adoption of telehealth in mental health systems saw steady gains in the years before the pandemic in rural and non-rural areas.^{52, 53} Responding to the need to provide socially-distanced services, health systems rapidly shifted to telehealth service provision following the spread of COVID-19. Adapting to this reality, the federal government and states took swift action. While the details differ somewhat across states and federal programs, temporary legal and regulatory flexibilities were enacted to enable the provision of telehealth services, including:

- reducing restrictions on out-of-state providers;
- allowing telehealth services to be provided by additional provider types;
- enabling initial provider visits to take place via telehealth;
- allowing reimbursement for telephone only visits;
- allowing reimbursement of telehealth visits in a wider variety of settings, including homes;
- allowing the provision of services through non-HIPAA compliant platforms; and
- eliminating payment disparities between telehealth services and in-person services.^{54,55}

Because many of these changes designed to respond to the pandemic are temporary, mental health systems and providers face a lot of uncertainty and may have to adapt to a new regulatory and policy environment as COVID-19 rates decline.

A study that analyzed half of all private insurance claims in the United States from February of 2020 to April of 2020 found a 2900% increase in mental health telehealth claims.⁵⁶ The number of claims reduced somewhat in the following months, but remained at 2600% of pre-pandemic levels as of December 2020. Medicaid and CHIP also saw a large growth in the use of telehealth during this period.⁵⁷ Another study that examined a national sample of commercial and Medicare advantage claims from January to June 2020 found that telehealth accounted for 56.8% of total psychiatry visits, 50.8% of social work visits, and 49.1% of psychology visits during this period.⁵⁸

While the ability to provide services via telehealth enabled access to mental health services during the pandemic, it is not a panacea. Telehealth may not be as effective for all interventions and conditions. While telehealth's efficacy for depression and anxiety is more established, there is less evidence for its use with conditions like schizophrenia.⁵⁹ Although initial reports for some providers have indicated success in using telehealth to serve individuals with SMI.⁶⁰ Some types of mental health services, such as medication visits, may be better suited to telehealth delivery. As a result, the shift to telehealth may also impact the types of services that individuals seek out or continue to access.

In many rural areas there are technological barriers to accessing telehealth. These include lack of access to broadband or limited bandwidth; poor cellular coverage; limitations in clients' phone plans that limit the number of minutes or amount of data that they can use; and lack of access to necessary technology. Household bandwidth can also be an issue. During the pandemic multiple members of households are often competing for bandwidth with children and youth logging in to school online, and adults working remotely when possible.⁶¹ Some people do not have access to technology necessary to participate in telehealth, and with some groups experiencing less access than others, including older Americans, people with disabilities,⁶² and people living in poverty.⁶³ It is important to note that these groups are all

overrepresented in rural areas and public mental health systems. Some systems and providers have attempted to address these concerns by providing devices to help people being served access telehealth services.^{64, 65, 66} Telehealth is also not a solution when provider capacity within organizations is severely limited. There are still only so many slots available for a psychiatrist to see clients whether they are providing services via telehealth or in-person.

Providers face considerable uncertainty as it is not clear whether regulatory flexibilities enabling current telehealth practices will extend past the pandemic. As people return to more in-person services, providers and consumers will need to figure out what is the best use of telehealth, for which individuals it is most effective, and if there are interventions that are more effective in-person. Providers in rural areas may need to make trade-offs in some of these areas. For instance, it may be that group interventions are more effective in person, but this is outweighed by the convenience for providers and participants, who may have to drive for hours to participate in these sessions. Taking all of this into account, it is clear that telehealth has an important role in mental health systems moving forward. It provided safe access to services during the pandemic and created a sustainable business model for many providers through the pandemic. In general, and in rural areas specifically, it offers a more convenient way for people to access many mental health services. In addition to direct service delivery, telehealth may be used to support consultation with other providers, such as primary care providers or less specialized behavioral health care providers, so may be a way of bolstering the capacity of the existing workforce in rural and remote areas.

Program Spotlight – Telehealth Expansion in a Remote Area

Lindsey McCarthy, MSW, Executive Director, Southern Plains Behavioral Health Services

Southern Plains Behavioral Health Services (Southern Plains) serves Gregory, Todd, Tripp, and Mellette Counties in South Dakota. Their service area includes the Rosebud reservation and land trust, the home of the Rosebud Sioux Tribe, a branch of the Lakota people. The area of the state that they serve is extremely remote, with a population under 25,000 people across the four counties as of the 2010 census. Southern Plains provides services to over 700 people, a majority of whom have Medicaid coverage or receive services funded by the state.

Southern Plains has provided some telehealth services since 2006 but was working to expand their telehealth capacity before the COVID-19 pandemic. They had hosted on-site telehealth training for all of their staff in the year before the pandemic with the intention of expanding these services, but the pandemic greatly accelerated their schedule for telehealth adoption. In the second quarter of 2020, they found themselves moving almost all services to delivery through telehealth.

The shift to telehealth has been largely advantageous for Southern Plains, greatly reducing staff transportation time and improving access for clients. At the beginning of the pandemic, their psychiatric no shows decreased significantly. Some clients expressed interest in going back to in-person and stopped engaging after the first few months of remote services, but most clients have been happy with continued telehealth services. Southern Plains has been able to provide a variety of services remotely. For some clients, participation in groups required a two hour drive each way before the shift to telehealth, so remote groups have been a major improvement. In their work with clients who have more complex or serious conditions, the telehealth hasn't been a major barrier. In some cases it has enabled staff to have multiple shorter remote contacts with clients in a week

instead of one in-person visit. Southern plains moved to providing crisis assessments remotely using telehealth, offering the service remotely to local hospitals and the jail, which has worked well.

Internet access has been a barrier for many clients. Some clients also do not have the cell phone minutes or data available in their phone plans to consistently participate in telehealth. There are also issues of mobile network coverage and there are some areas across the four-county area where mobile phone service is spotty or unavailable.

Moving to telehealth has also resulted in organizational benefits for Southern Plains. Having clinicians on the road throughout the day made it difficult to schedule meetings and coordinate. With most people working remotely and providing services via telehealth, there are more regular meetings with more staff present. Remote work has also forced staff to use online systems, which has also improved coordination.

The Southern Plains experience with telehealth over the past year was captured in something Ms. McCarthy said as we wrapped up our interview, “We spend less in gas, our utility bills are lower, and we’re able to reach more people. We need to learn from COVID to make sure we are reaching as many people as we can.” After adapting to conditions under the pandemic, Southern Plains faces additional uncertainty as COVID-19 transmission rates decrease. Much of the telehealth expansion that has been possible has been a result of temporary regulatory flexibility in response to COVID-19, so the continuation of current expanded telehealth practices will depend on future state and federal policies.

Building the Array of Effective Practices in Rural and Remote Settings

There is an array of evidence-based practices that have been shown to improve outcomes for people with mental disorders, but there are challenges in implementing these in rural or remote areas. Especially for individuals with more intensive or complex needs, these interventions, such as assertive community treatment (ACT), supported employment, permanent supportive housing, or high-fidelity wraparound, are not only focused on providing psychosocial interventions or psychotropic medication, but more broadly connecting people with a variety of community supports and addressing social determinants of health. As a result, these are practices that, while telehealth may support them or be incorporated into them,^{67, 68} rely on face-to-face contact and services delivered in community settings. Many of these were developed in urban and suburban settings and are built on assumptions around service infrastructure, population density, and workforce that may not hold true in rural settings. There has been some work to systematically adapt and evaluate evidence-based practices in rural and remote settings, but it is limited.⁶⁹

The challenges involved in implementing these evidence-based practices in rural areas varies by practice. For practices like ACT that rely on a robust interdisciplinary team and intensive community contact, staffing, transportation, and economies of scale may be challenging.⁷⁰ Some practice models face focus-specific challenges in rural and remote areas, such as the general lack of job opportunities, which may impact supported employment programs,⁷¹ or the lack of available affordable rental housing, which may impact permanent supportive housing and other housing supports.⁷²

Adaptation of evidence-based supports in order to successfully deliver them in rural and remote areas may mean adapting established models or identifying core components of EBPs, and finding effective

ways to deliver these components or achieve the same goals through staffing and service delivery models that are possible in rural and remote areas. EBPs must also be responsive to cultural issues and should be adapted to the culture of the individuals receiving them.⁷³ This should especially be a priority in the delivery of services to tribal populations.⁷⁴ Given the great variation in populations, capacity, and challenges in rural and remote areas, it is likely that there won't be a one-size-fits-all adaptation of EBPs that will enable their use across the United States, but that a range of approaches will need to be developed and deployed.

Program Spotlight – Incorporating Telehealth into Program for Assertive Community Treatment (PACT) Team Operations

Dr. Charlie Swanson – Medical Director, Piedmont Community Services Board

Piedmont Community Services Board (CSB) in southern Virginia was scheduled to undertake an independent fidelity review for their PACT team in March 2020 when the pandemic began. PACT, also known just as ACT in many places, is a multidisciplinary team approach with assertive outreach for people with SMI who require an intensive level of support to remain stable while living in a community setting. Instead of going through the fidelity review process, Piedmont CSB found itself in the position of adapting all of its operations, including the PACT team, to operate as safely as possible during the pandemic. The PACT team serves 84 people in Henry County and the city of Martinsville in southern Virginia. The team includes a psychiatrist, four nurses, a pharmacy technician, a peer, two counselors and several case managers.

In the operations of the ACT team, transportation challenges are a major consideration given the distances that need to be traveled to see clients. For several years the team has been using telehealth to facilitate visits with the psychiatrist, Dr. Charlie Swanson. This proved advantageous when the COVID-19 pandemic began because clients were already used to telehealth services. The team was able to shift some contact to telehealth, for instance, checking in with clients, but many ACT team functions still required in-person visits. Shortages of personal protective equipment (PPE) were a problem, especially in the early stages of the pandemic. Dr. Swanson reported purchasing ponchos for ACT team members providing in-person services from the Tractor Supply Company at one point because of shortages in PPE.

Dr. Swanson reported that clients did fairly well through the first few months of the pandemic, summoning internal resources to remain stable. Over time though, the stress of the pandemic has impacted the PACT clients. Clients showed great concern for the wellbeing and safety of ACT team members and many embraced social distancing measures to protect the staff. Despite shifting services to telephonic contact when possible and taking precautions, some members of the ACT team contracted COVID-19.

While most services offered by Piedmont CSB shifted to telehealth, there were limitations with how many PACT functions could be done over the phone. Some PACT clients met with team members via Zoom but delivering services via telehealth had several limitations. Given the seriousness of the mental illnesses experienced by the people served by the PACT team, they were not always able to communicate their needs or receive support over the telephone. As Dr. Swanson put it, "Telephonic is helpful, but it's not like seeing folks face to face." Also, while mobile service was generally available in Henry County, many clients had a limited broadband access and a number of phone minutes or broadband access through their phone plans, so were limited in how much they could participate in telehealth. Delivering in-person services also enabled team members to provide other supports, such

as taking groceries to the people they worked with, which became more important given the disconnection and isolation that people experienced during the pandemic. Some services were particularly difficult to deliver during the pandemic, such as groups that focus on SUD, social support, and wellness, which didn't work over Zoom for people receiving ACT. Although Dr. Swanson felt that the use of telehealth in other Piedmont CSB services would continue past the pandemic, he anticipated that the PACT team would revert to more in-person contact for the majority of the team, as they had operated before the pandemic, but continuing to offer psychiatric visits remotely.

Developing Rural Crisis Systems

The United States is currently undergoing an intensive period in the development of behavioral health crisis services. With the rollout of a national "988" crisis hotline, the creation of a crisis set aside within the Community Mental Health Services Block Grant, enhanced Medicaid coverage of mobile crisis services and a public dialogue of the appropriate role of law enforcement in the response to behavioral health crises,⁷⁵ attention within states to crisis services has never been greater.

Rural and remote communities confront several major challenges that impact the development and delivery of crisis systems and services. Large geographic areas to cover, combined with limited available resources, often leads to long wait times to access services when an individual experiences a behavioral health crisis in these communities. Long distances to travel to services that are located primarily in urban areas, such as inpatient care, and the availability of transportation itself to services may be difficult.⁷⁶ Workforce shortages and challenges related to recruitment and retention of qualified professional staff to ensure quality crisis services delivery also persist in rural and remote communities.⁷⁷

Strategies recommended in *SAMHSA's National Guidelines for Crisis Care: A Best Practice Toolkit* to address these challenges largely center on leveraging partnerships with area first responders to strengthen crisis response abilities and incorporating technologies like telehealth to make the best use of available resources in developing and delivering crisis care.⁷⁸ Regional partnerships are sometimes formed to share resources and make services like mobile crisis available in rural and remote communities. However, relatively low demand for these services can still make funding and staffing teams for 24/7 availability a challenge.⁷⁹ Capitalizing on available human resources like volunteer or on-call clinicians can assist in making crisis services available when needed. Alaska, for example, trains citizens as Behavioral Health Aides (BHAs) employed by their regional tribal health organizations to provide on-call responses to individuals who are experiencing a behavioral health crisis.⁸⁰ Collaboration with area first responders like EMS may be leveraged to assist with transportation to care, which is also difficult to fund and provide.

Pre-COVID-19, some rural and remote communities were able to both offer access to limited licensed and/or credentialed clinicians and other professional staff (e.g., psychiatry), and equip existing first responders with resources to connect individuals in crisis with proper screening and next step crisis care by incorporating technology like telehealth. For example, in some rural Colorado communities, paramedics are trained to do an initial screening and then connect individuals via telehealth to a qualified mental health professional who can further guide needed follow-up care.⁸¹ Colorado was also exploring training volunteers who are bachelor's-level providers or peers in rural communities pre-COVID to use tablets to virtually connect individuals in crisis to care using telehealth.⁸²

The COVID-19 pandemic may have shifted priorities and/or resources away from the piloting of new crisis care strategies like these, and also necessitated decreasing some crisis services capacity due to social distancing requirements (e.g., in crisis stabilization units).⁸³ It also highlighted major challenges related to mental health and access to care during crises in rural and remote areas, while accelerating the use of new and emerging models of delivering crisis care. COVID-19 presented an opportunity to rapidly expand the use of virtual care using telehealth. This has been effective in addressing some services access issues in rural and remote communities by allowing for modified payment mechanisms and new provider types to bill for services delivered via telehealth. The increased availability of telehealth may have also helped to overcome some of the stigma associated with seeking mental health care in rural communities by offering alternatives to office-based treatment. However, the surge in the use of telehealth has also highlighted the ongoing challenges in rural and remote communities related to limited broadband connectivity, as well as limits on affordability of and access to devices like tablets in order for individuals in these communities to take advantage of virtual behavioral health services and supports, including crisis care.⁸⁴

Conclusion

It will be years before more complete data is available that shows the short- and long-term impacts of COVID-19 on the prevalence of mental disorders and service delivery in rural and remote areas. The United States mental health system embarked in an experiment, shifting overwhelmingly to telehealth delivery of mental health services during the COVID-19 pandemic. While this has broad implications for the mental health system, the impact is even larger for rural and remote mental health systems, where telehealth has long been seen as a possible solution to access problems. The field will need to do extensive work to understand where telehealth has worked and where it has not.

People in rural areas may access mental health services at similar rates to other areas of the United States, but they do not have equivalent access to intensive or specialty services. There is considerable work to be done to develop rural and remote mental health systems, building a workforce that draws on a wider variety of mental health professionals, leveraging advances in telehealth, identifying people in need of more intensive and specialized services, and adapting EBPs to ensure that people get the services they need. This is also true for tribal communities in rural and remote areas. As tribal mental health systems develop and adapt services to better meet the needs of AI/AN people, there is great potential meet the significant needs that exist in these communities.

As COVID-19 restrictions lift and more data becomes available, policymakers and practitioners will get a better sense of the extent to which people in rural and remote areas received the mental health services they needed during 2020 and 2021. Meeting the needs of people in rural and remote areas will require work at the federal, state and local levels. Federal and state policymakers must assess the proper role of telehealth, informed by clinical experience, and adjust laws and regulations accordingly. They must also work with providers, researchers, and the communities and populations being served to identify strategies that will contribute to a robust, interconnected, and evidence-based system of mental health care in rural and remote areas.

Thank you to Jessica Black from the University of Alaska Fairbanks, Chris Fore, Tamara James, Marcy Ronyak, and Glorinda Segay from the Indian Health Service, Heather Gotham, Dennis Mohatt, Ann Skinstad, and Teresa Brewington from the Mental Health Technology Transfer Center Network, Charlie Swanson from the Piedmont Community Services Board, and Lindsey McCarthy from Southern Plains Behavioral Health Services, who all participated in interviews to inform the content of this brief.

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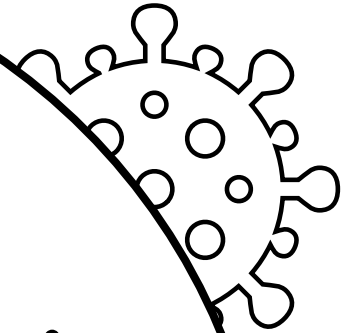
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Funding Opportunities for Expanding Crisis Stabilization Systems and Services

No. 8

NASMHPD

Ready to Respond:
Mental Health Beyond Crisis and COVID-19

September 2021

Funding Opportunities for Expanding Crisis Stabilization Systems and Services

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Cover Art by Malkah Pinals

***Eighth in the 2021 Ready to Respond Series of Ten Technical Assistance Briefs
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September 2021

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Recommended Citation

Beronio, K.K. (2021). *Funding Opportunities for Expanding Crisis Stabilization Systems and Services*. Technical Assistance Collaborative Paper No. 8. Alexandria, VA: National Association of State Mental Health Program Directors.

This work was developed under Task 2.2 of NASMHPD's Technical Assistance Coalition contract/task order, HHSS283201200021I/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

Abstract:

Recent dramatic increases in federal funding for mental health care and addiction treatment have created significant new opportunities to expand access to behavioral healthcare. At the same time, designation of a three-digit nationwide crisis hotline (988) has highlighted the need for increased crisis call center capacity and crisis stabilization services in most communities. Development of statewide crisis stabilization systems that provide support through call centers, mobile crisis teams, and crisis stabilization centers can provide an essential framework for improving connections to needed services and supports while simultaneously decreasing reliance on emergency departments and law enforcement. Unprecedented increases in federal block grants and increased Medicaid support for mobile crisis and home and community-based services offer states a multi-faceted opportunity to significantly improve care for individuals experiencing mental health or addiction crises. This paper discusses the following recent developments and implications for improving access to crisis stabilization services.

Highlights:

- Supplemental mental health and substance use disorder block grant funding can support the leadership, planning, coordination, and implementation steps needed to develop comprehensive statewide crisis stabilization systems. This increased federal funding along with substantial new grant opportunities can incentivize and support providers to expand crisis stabilization programs and services.
- Existing and newly enacted Medicaid authorities can bolster expanded crisis stabilization programs and provide reliable funding for these programs going forward. This paper details various opportunities in Medicaid to finance crisis stabilization programs and services including a recently enacted enhanced federal Medicaid match for mobile crisis teams and increased federal Medicaid funding for home and community-based services;
- Expanded coverage of telehealth is critical for on-going improvements to crisis stabilization systems. This paper discusses the importance of continued coverage of telehealth after the Covid-19 public health emergency ends, including services via audio-only technology. It also describes some recent improvements to Medicare coverage of tele-behavioral health;
- This paper also outlines some promising opportunities to support crisis stabilization systems through alternative payment models and demonstrations.

Recommendations for the Post-COVID-19 Future:

1. Invest in statewide crisis stabilization systems;
2. Improve coverage of crisis services and reimbursement rates to increase availability of crisis stabilization programs; and
3. Support providers to expand access to crisis stabilization services.

The paper concludes with recommendations for additional federal policies to support state crisis stabilization systems and programs.

Several developments over the past year, driven in part by COVID-19, have created a unique opportunity to increase access to mental health and substance use disorder services, in particular crisis intervention and stabilization services. These developments include the enactment of a federal law designating 988 as a behavioral health crisis hotline that will be easy to remember and available nationwide by July 2022.¹ In addition, the significant impact of COVID-19 on behavioral health and the spike in overdose deaths during the pandemic have led Congress to dramatically increase funding for mental health and substance use disorder federal block grants and create significant new opportunities to support behavioral healthcare in Medicaid. Furthermore, several high-profile, tragic incidents have led to growing recognition of the need for alternatives to law enforcement responses to behavioral health emergencies, particularly among people from racial minority or disadvantaged communities. This paper will focus on how new federal funding opportunities can support development of crisis stabilization systems that can serve as alternatives to unnecessary use of emergency departments and law enforcement to assist individuals experiencing behavioral health crises.

Behavioral Health Before, During, and After the COVID-19 Pandemic

Before the pandemic, the United States was already experiencing multiple behavioral health crises. Although overall overdose deaths had declined slightly in 2018, the number of people dying from overdoses of synthetic opioids, cocaine, and psychostimulants was increasing at an alarming pace.² Rates of suicide had also been rising steadily, up 35% between 1999 and 2018.³ Serious behavioral health conditions had become so prevalent and elevated, they had driven down overall life expectancy in the United States.^{4,5}

During the COVID-19 pandemic, national surveys have repeatedly shown dramatic increases in the incidence of anxiety and depression.⁶ Suicidal ideation increased,⁷ and drug overdoses increased almost 30% with more than 93,000 deaths in 2020.⁸ Although suicide rates seemed to level off and even decreased last year,⁹ these overall findings are preliminary and differ by demographic subgroups.

As concerns about COVID-19 infection subside, mental health and substance use disorders may remain elevated for many people. Experiences with epidemics in the past indicate that the impact on behavioral health may continue for years to come.^{10,11,12} Children and adolescents are at risk of depression and anxiety during and after the pandemic ends according to a review of more than 80 studies on the impact of social isolation.¹³ Therefore special attention should be paid to them and other vulnerable populations, including minorities and underserved communities at greater risk of on-going challenges.

Designation of 988 Sparks Increased Support for Crisis Stabilization Services

The National Suicide Hotline Designation Act (Pub. L. 116-172), establishing 988 as a nationwide toll-free mental health crisis and suicide prevention hotline, presents a significant new opportunity to address increased behavioral health needs. An easy to remember three-digit number will be an important new resource for people struggling with behavioral health crises as well as their family and friends. The Act requires that all calls to 988 be directed to the pre-existing National Suicide Prevention Lifeline funded and overseen by the Substance Abuse and Mental Health Services Administration (SAMHSA) or the Veterans Crisis Line overseen by the U.S. Department of Veterans Affairs. An order by the Federal

Communications Commission has set the deadline for telecommunications providers to implement this change as July 16, 2022.¹⁴

In recognition of the expected increase in call volume and the need for additional capacity to answer these calls, Congress included a provision in the 988 Designation Act clarifying that states may enact fees on telephone services including mobile phone services.¹⁵ In particular, the Act specifies that nothing in the legislation or the Communications Act of 1934 or otherwise prohibits states from imposing fees on telephone services including mobile phones for 988 related services. These fees are to be used for routing calls made to 988 to a crisis center and providing crisis outreach and stabilization services in response to these calls. Several states have enacted legislation authorizing such fees.

In addition, Congress increased funding for the Lifeline network that will underpin 988 by \$5 million in the SAMHSA FY 2021 appropriations included in the Consolidated Appropriations Act (Pub. L. 116-260) (for a total of \$24 million for FY 2021). The President’s Budget for FY 2022 calls for \$102 million for the National Suicide Prevention Lifeline. Furthermore, the House of Representatives, Labor, Health and Human Services, and Education FY 2022 funding bill reported out of the full Appropriations Committee on July 15, 2021 includes over \$113 million for the Lifeline.

Improvements to the Lifeline call center network as well as expansions of mobile crisis teams and crisis receiving and stabilization centers are needed to improve services and supports for individuals struggling with behavioral health crises. Furthermore, these crisis stabilization systems and services can help decrease over-reliance on emergency rooms and law enforcement responses to behavioral health crises.^{16,17}

SAMHSA has issued National Guidelines for Behavioral Health Crisis Care that focus on several levels of crisis intervention and stabilization including regional crisis call centers, mobile crisis teams, and crisis receiving and stabilization centers.¹⁸ These guidelines envision regional call centers that are available 24/7 and clinically staffed to provide telephonic crisis intervention services. These centers should triage calls to facilitate assessments and coordinate additional support as needed including ideally with the capacity to dispatch mobile crisis teams if necessary.¹⁹

Mobile crisis teams can help resolve and de-escalate situations when an individual is experiencing a crisis in the community or at the person’s home. In addition, back-up by psychiatrists or other clinicians should be available. Furthermore, mobile crisis response providers should have good relationships with mental health and addiction treatment providers in their communities including crisis stabilization residential beds and inpatient settings.

Recent State Laws Funding Crisis Stabilization Services

Colorado (SB21-154)

-with a telecommunications user fee

Nevada (SB 390)

- with a telecommunications user fee

Virginia (SB1302)

-with a telecommunications user fee

Washington (HB 1477)

-with a telecommunications user fee

Utah (SB155)

-appropriates funding
-no telecommunications user fee

For those who require more assistance than a mobile crisis team can provide, the SAMHSA National Guidelines call for crisis receiving and stabilization centers and sub-acute crisis residential facilities. Crisis receiving and stabilization facilities are open 24 hours a day, seven days a week and are staffed with multidisciplinary teams that include prescribers, nurses, clinicians, and peers. The Guidelines call for these centers to accept walk-ins, ambulance, fire, and police drop-offs.

Leadership is Key for Developing and Supporting Crisis Stabilization Systems

The advent of 988 has drawn attention to the need for collaboration and investment in expanding crisis stabilization programs and services into coordinated systems. However, leadership and concerted efforts are needed to direct various substantial new funding streams as well as to coordinate many critical stakeholders into developing coordinated crisis stabilization systems that include at least the core components described in the SAMHSA National Guidelines.

State mental health and substance use disorder agencies have the expertise in behavioral health treatment and crisis stabilization as well as relationships with many of the various stakeholders that are required for leading this effort. Moreover, these agencies oversee use of mental health and substance use disorder block grant funds that Congress has dramatically increased over the past year to facilitate and encourage bold action by the states in addressing new and on-going behavioral health crises.

Substantially Increased Block Grant Funding Creates New Opportunities

At the end of 2020 and again this spring, Congress infused significant new funding into the MHBG and SAPTBG as part of the Consolidated Appropriations Act, 2021 (CAA)²⁰ and through the American Rescue Plan Act (ARPA).²¹

In the CAA, in addition to the regular appropriations for the block grants and other programs administered by SAMHSA, supplemental appropriations provided an additional \$825 million for the MHBG and \$1.65 billion for the SAPTBG for FY 2021. SAMHSA announced award of these funds March 11, 2021,²² and states have until March of 2023 to expend these supplemental funds.

Overview of SAMHSA Block Grants

Annual appropriations for formula based block grants administered by SAMHSA provide important federal funding to support state mental health and SUD services and systems. Most recently, these block grants, the Community Mental Health Services Block Grant (MHBG) and the Substance Abuse Prevention and Treatment Block Grant (SAPTBG), were funded at over \$757 million and \$1.858 billion respectively for FY 2021.¹ Congress and SAMHSA set general parameters on the use of these funds while leaving distributions and additional refinements to the state mental health and SUD agencies. Although other funding sources, e.g., Medicaid, cover a much higher percentage of overall spending on mental health and SUD services, the block grants represent a partnership between the federal and state governments specifically aimed at addressing mental health and SUD issues. In addition, these block grant funds provide a safety net for those who need mental health and SUD services.

In this legislation, Congress also set aside \$35 million of the regular FY 2021 MHBG appropriation specifically to fund crisis stabilization programs. The House Appropriations Committee report included the following description of this set-aside:

“Furthermore, the Committee directs a new five percent set-aside of the total for evidence-based crisis care programs addressing the needs of individuals with serious mental illnesses and children with serious mental and emotional disturbances. The Committee directs SAMHSA to use the set-aside to fund, at the discretion of eligible States and Territories, some or all of a set of core crisis care elements including: centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, evidence-based protocols for delivering services to individuals with suicide risk, and regional or State-wide crisis call centers coordinating in real time.”²³

In the notices of awards sent to states regarding their FY 2021 MHBG funding awards, SAMHSA included several pages of guidance regarding the new set-aside for crisis services [See Appendix A]. SAMHSA specified that these set-aside funds must be used to finance “core crisis care elements including centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, evidence-based protocols for delivering services to individuals with suicide risk, and regional or state-wide crisis call centers coordinating in real time.”²⁴

States were required to submit revisions to their MHBG plans with detailed descriptions of the status of the state’s crisis system including access to local crisis call centers, availability of mobile crisis units, and the availability and/or utilization of short-term crisis receiving and stabilization centers. States were also required to describe proposed or planned activities for this 5% set-aside funding. In addition, SAMHSA stated that “states may need to dedicate the rest of the current fiscal year to planning, training, and/or infrastructure development while targeting program implementation for the following year.”²⁵

With the ARPA, enacted just a few months later in March of 2021, the federal government provided an additional \$1.5 billion for the MHBG and \$1.5 billion for the SAPTBG. States have until September 30, 2025 to use these funds. SAMHSA announced these state allocations of these funds on May 18, 2021.²⁶ Although the specific set-aside provision for crisis stabilization was not included in the ARPA legislation, SAMHSA sent guidance to state mental health commissioners and substance use disorder directors encouraging states to focus some of the ARPA block grant funding to develop a behavioral health crisis stabilization continuum [in Appendix B]. SAMHSA urged states to ensure crisis services are available to various populations including people living in remote areas and underserved communities as well as children with serious emotional disturbances.

List of Abbreviations

ARPA	American Rescue Plan Act
CAA	Consolidated Appropriations Act, 2021
MHBG	Community Mental Health Services Block Grant
SAPTBG	Substance Abuse Prevention & Treatment Block Grant

Table 1: Recent Increases in Mental Health and Substance Abuse Block Grants (Dollars in Millions)

	FY 2020 Appropriations Enacted 12/2019	FY 2021 Appropriations Enacted 12/2020	FY 2021 CAA Supplemental Appropriations Enacted 12/2020	ARPA Enacted 3/2021
MHBG	\$722.571	\$757.571 (including \$35 million for crisis set-aside)	\$825.000	\$1,500.000
SAPTBG	\$1,858.079	\$1,858.079	\$1,650.000	\$1,500.000

More recently, the President’s Budget for FY 2022 proposed “a set-aside of \$75 million of MHBG funds to support state efforts to build much needed crisis systems.”²⁷ This proposed increase more than doubles the amount provided for FY 2021 and is another step toward a 10% set-aside that many advocates are urging Congress to enact. Furthermore, the House Labor, Health and Human Services, and Education FY 2022 Appropriations bill proposes to increase the MHBG to \$1.58 billion and includes a 10% crisis set-aside.²⁸ This bill would also provide \$100 million for a Mental Health Crisis Response Pilot Program to establish or expand mobile crisis teams. In addition, the bill would also increase the SAPTBG by \$1 billion to \$2.8 billion and increase the State Opioid Response Grants by \$500 million to \$2 billion with a 10% set-aside for recovery services. Although the federal FY 2022 appropriation legislation is not yet final, these developments indicate that increased block grant funding levels and the set-aside for crisis services may be maintained at least in some fashion in the near term.

Supplemental Block Grants Can Support Development of Statewide Crisis Stabilization System

In guidance regarding the ARPA supplemental MHBG funding [in Appendix B], SAMHSA specifically recommends that states use these funds to develop partnerships among crisis continuum stakeholders including--

- Operators of Lifeline/988 call centers,
- Law enforcement,
- Providers of crisis stabilization services
- Hospitals and health systems,
- Housing authorities,
- Peer recovery services providers, and
- Substance use treatment providers

Development of crisis stabilization programs and services into coordinated behavioral health crisis systems will require collaboration with a number of additional entities including --

- State Medicaid agency leaders,
- Insurance commission officials,

- Emergency transportation providers,
- 911 operators,
- Other hotline operators in the state,
- People with lived experiences of behavioral health conditions and their families,
- Representatives of underserved communities, and
- Other state and local regulatory agencies that oversee emergency services (if applicable).

The SAMHSA ARPA guidance also recommends use of the additional MHBG funds to--

- Support implementation of information technology including increasing availability of broadband,
- Fund implementation of electronic health records by behavioral healthcare providers,
- Support use of Global Positioning System (GPS) technology to improve crisis response times,
- Finance implementation of texting capabilities among providers,
- Support the use of telehealth including for medication assisted treatment, and
- Fund implementation of electronic bed registries.

These activities and resources highlighted by SAMHSA comprise fundamental ways the federal block grants can be invested to support development of comprehensive coordinated crisis response systems. Flexible funding like the MHBG and SAPTBG can more readily support these types of investments than programs like Medicaid, Medicare, or private insurance programs which nonetheless should cover the services provided through crisis systems and programs.

State agencies should consider using the supplemental block grant funds to support a number of additional activities aimed at developing statewide crisis stabilization systems. An initial step could be an assessment of existing providers of crisis stabilization services including any existing hotlines and call centers. This planning should also include an assessment of which call centers in the state already participate in the Lifeline/988 network, what their capacity will be to accept increased calls coming in through 988, and whether additional capacity to answer 988 calls will be needed. Planning for coordination among existing crisis hotlines within the state would be helpful. In addition, protocols for how 988 will interface with 911 must be developed.

Block grant funding could also support an environmental scan of the existing mobile crisis units and crisis stabilization centers

Summary of Steps for Building Crisis Stabilization Systems

-Assess availability of existing crisis hotlines, call centers, mobile crisis, and crisis stabilization centers and address barriers in regulations and reimbursement

-Determine which call centers participate in the SAMHSA Lifeline and assess their capacity to respond to 988 calls

-Develop protocols for responding to 988 calls and other hotlines including 911 and for coordinating with other call centers and crisis responders in the region and/or state

-Provide training to crisis services personnel on how to provide equitable responses to disadvantaged communities

-Implement electronic systems for tracking availability of mobile crisis teams and openings in crisis stabilization facilities in real time

- Amend state laws that block use of alternative emergency response systems and create other barriers to

-Expand use of peers for crisis stabilization and expand scopes of practice for other behavioral health practitioners as well

- Collect data to assess impact and ensure quality

throughout the state to determine where additional services and programs exist and where there are gaps or improvements are needed. An assessment of Medicaid reimbursement rates for crisis stabilization services could help identify barriers to broader availability of services. In addition, block grant funding could support implementation of best practices for staffing mobile crisis units and other crisis stabilization programs. Crisis system development should support training for crisis services personnel to ensure equitable responses to disadvantaged communities. Furthermore, states should examine whether existing laws or regulations may impede development of alternatives to existing emergency response systems including rules against transporting individuals to alternative settings that are not emergency departments.

In addition, state agencies should collaborate on improving technological support for crisis response. Block grant funding could be used to improve the capacity of crisis response providers to provide services via telehealth. States should also consider using block grant funds to develop or improve existing electronic systems for tracking openings in crisis stabilization facilities and programs in real time.²⁹ In addition, these activities should include planning and funding data collection improvements and quality assurance programs for crisis stabilization services.

In light of widespread shortages of behavioral health providers, it is important that state behavioral health leaders reassess the limits on the types of providers permitted to offer behavioral healthcare especially crisis stabilization services. In this regard, states should assess whether existing scope of practice laws are unreasonably limiting practitioners' authority to assess and support those experiencing behavioral health crises.

State efforts to plan and fund increased availability of crisis stabilization services and systems should include support for coverage of peer support specialists as part of crisis stabilization teams. Peers can provide a knowledgeable and calming presence that can greatly help to deescalate a behavioral health crisis. There is growing evidence on the effectiveness of peer support services at improving outcomes for individuals struggling with mental illness or addiction while reducing costs.^{30,31} Some 39 states cover peer support services in their Medicaid programs with 23 states covering them for mental health and addiction, 12 states only covering their services for mental health, and four for addiction only.³² Block grant funding could be used to assess barriers to increased use of peers for behavioral health crisis response and to develop strategies for securing on-going support for peer support services, e.g., through expanding Medicaid coverage.

Medicaid Coverage of Peer Supports

States may cite the following Medicaid authorities to support coverage of peer support services:

- Rehabilitative services optional authority;
- Medicaid managed care plans under section 1915(b) authority;
- as a home and community-based services Medicaid state plan benefit under section 1915(i) or through a HCBS waiver under 1915(c).
- as part of section 1115 demonstrations;
- included in the benefits that Certified Community Behavioral Health Clinics must provide as part of the on-going Medicaid demonstration and expansion grant program.

Crisis system planning should also include an assessment of how crisis stabilization services are currently funded in the state as well as in other states including with fee-for-service Medicaid coverage, any managed care arrangements as well as whether providers are billing Medicare or commercial insurance for any of the services they provide. As 988 may significantly increase calls to behavioral health hotlines and demand for crisis stabilization services, support for these services should be increased with sustained funding sources. A discussion of how Medicaid can support these services follows. Moreover, coverage of crisis intervention and stabilization services provided to individuals covered by Medicare and private insurance should not fall solely on state and local governments as is now often the case.

States should encourage and support crisis stabilization providers to bill Medicare for covered services provided to Medicare beneficiaries. Medicare covers crisis psychotherapy (CPT Codes 90839 and 90840),³³ and according to CMS, 90839 is one of the most commonly used codes for billing Medicare for mental health services.³⁴ Although only certain provider types are eligible to bill these codes including psychiatrists, psychologists, and clinical social workers, and crisis stabilization providers likely will not have many higher-level credentialed providers on staff or at least not available 24/7, they may be able to take advantage of telehealth psychotherapy and “incident to” billing policies for higher credentialed providers. The “incident to” policy allows Medicare-enrolled providers to bill for services technically provided by an employee whom they supervise thereby allowing Medicare to reimburse for services provided by a broader array of practitioners.³⁵ Furthermore, Medicare covers crisis psychotherapy when provided via telehealth including audio-only telehealth.³⁶ Therefore, a crisis stabilization services provider may be able to leverage the capacity of a small number of higher credentialed staff to provide services that can be covered by Medicare, particularly since CMS recently clarified that supervision for “incident to” services may be provided via two-way audio-visual technology.³⁷

State governments should also use their regulatory leverage to ensure commercial insurers contribute to covering the cost of crisis stabilization services either through fees or by including crisis services providers in their provider networks. It would also be important to ensure that the benefits for crisis stabilization services in state regulated plans are comprehensive.

Several states have acted upon the provision in the 988 Designation Act encouraging implementation of fees on telephone services to fund development of crisis stabilization services.³⁸ However, it is not clear how many states will enact similar fees, and additional sources of on-going support for crisis stabilization services will be critical. As discussed below, new and existing opportunities in Medicaid offer promising new options for supporting crisis stabilization systems in a more predictable way.

Funding for Provider Implementation and Construction Costs is Needed to Expand Crisis Stabilization Programs

As gaps in availability of crisis stabilization services are identified, block grant funds could also potentially be used to help cover implementation, start-up, and improvement costs for new crisis stabilization services and programs in different regions or counties of the state as well as provider costs for standing up these services. These kinds of costs are not generally covered by insurers or healthcare coverage programs like Medicaid and Medicare. Start-up and improvement costs for providers of crisis stabilization services include hiring staff and developing billing capabilities so that providers can bill insurance and coverage programs like Medicaid and Medicare. The guidance issued by SAMHSA

regarding recent increases in the block grant funds encourages use of these funds to cover some of these implementation and improvement costs including coordination at the local level, adoption of health information technology including availability of broadband and cellular technology for providers, improving telehealth capabilities, and implementing electronic health record systems.

However, there are certain significant limitations on the use of block grant funding, including a prohibition on the use of Block Grant funds for construction costs. This limitation applies to both MH and SAPTBGs. Federal laws regarding the use of MHBG and SAPTBG specify that states may not use these funds “to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility”.³⁹ However, a waiver of the prohibition on use of funds for construction, although not land acquisition, is authorized in the SAPTBG.⁴⁰ To qualify for this waiver, states must demonstrate that adequate treatment cannot be provided in existing buildings. In addition, a state must have a plan that minimizes costs of construction, and the state must agree to provide a one-to-one match in cash for the federal funding used for construction. Nonetheless, in light of the substantial recent increases in funding for the SAPTBG, states may have more of an incentive and opportunity to apply for a waiver of the construction cost prohibition and utilize SAPTBG dollars to significantly support expansion of SUD treatment services.

Other recently enacted Covid-19 relief funding for states and localities can also help support development of crisis stabilization programs. The Coronavirus State and Local Fiscal Recovery Funding included in the ARPA is potentially an even more flexible source of funding than the SAMHSA block grants. The U.S. Department of Treasury awarded the \$350 billion in emergency funding to state, local, territorial, and Tribal governments on May 10, 2021. This funding can be used to cover costs incurred through December 31, 2024. The Department of Treasury announcement⁴¹ and interim final rule specifically refer to behavioral health services including “crisis intervention” and “hotlines or warmlines” as allowable uses of these funds.⁴³ There does not appear to be any prohibition on the use of these funds to cover construction costs. The allocations to the states and localities are posted on the Department of Treasury website.⁴⁴

Furthermore, the House of Representatives recently revived the practice of earmarking federal funding for local community projects and Members of Congress were invited to recommend specific local projects to the House Appropriations Committee for FY 2022 funding. The House Appropriations Committee included funding for a long list of these community projects in the FY 2022 appropriations bill reported out of the full Committee on July 15, 2021. Although funding for these projects is not final, many projects on the list (at least 135) focus on mental health and substance abuse. Moreover, at least fourteen projects are focused on funding crisis services, and some of these projects would specifically fund facilities and equipment costs related to providing behavioral health crisis services. The full list of projects is posted on the House Appropriations Committee website.⁴⁵

Grants for Community Mental Health Centers and Certified Behavioral Health Clinics Can Support Development of Crisis Stabilization Programs and Services

The CAA included significant new funding for discretionary grant programs that can help support implementation of crisis stabilization services, including \$825 million in grants for community mental

health centers (CMHCs). Applications were due on May 21, 2021 for these grants that may be used for the following purposes:

- Enhancing the capacity of CMHC staff to address crisis and emergency response;
- Supporting increased capacity for and availability of crisis beds;
- Expanding mobile crisis mental health services;
- Coordinating with crisis centers/hotlines to ensure that strong referral pathways are established and/or restored;
- Developing and implementing outreach strategies and referral pathways for vulnerable populations, such as minority populations and individuals residing in economically disadvantaged communities;
- Training and supporting peer staff to serve as integral members of the team to address mental health needs; and
- Providing diversion services to promote alternatives to hospitalization and incarceration, e.g., multiple intercept model.⁴⁶

This funding may not be used for major construction or renovations, but up to 20 percent of the total grant award for each budget period may be used for infrastructure development and up to \$75,000 may be used for renovations. A set of frequently asked questions posted by SAMHSA clarifies that:

“[I]nfrastructure development does not relate to construction or alteration/renovations of brick and mortar structures. Infrastructure in this context is systemic infrastructure activities that support services, for which there are no individual services delivered. Examples include the development and maintenance of a crisis-response capacity, including hotlines, mobile crisis teams, web-based check-in groups (for medication, treatment, and re-entry follow-up), drop-in centers, respite services, etc. Please note that on page 49 of the FOA, applicants may request up to \$75,000 for renovations and alterations of existing facilities, if necessary and appropriate to the project.”⁴⁷

Recent federal Covid-19 relief legislation also greatly increased funding for Certified Community Behavioral Health Clinic (CCBHC) expansion grants. These grants support provision of comprehensive behavioral health supports and care coordination by clinics that are also required to provide, among other services, 24/7 crisis stabilization services. The CAA allocated an additional \$250 million specifically for CCBHC expansion grants. In addition, ARPA provided an additional \$420 million for CCBHC expansion grants. The general prohibition on use of funds for construction also applies to CCBHC grants along with the allowance for up to \$75,000 for renovations. Nonetheless, these grants can be used to improve access to crisis intervention services including mobile crisis teams and peer supports.⁴⁸

Medicaid Can Cover Some State Agency Costs for Improving Crisis Stabilization Systems

In addition to covering crisis stabilization services, Medicaid can also support state development and implementation activities to improve access to crisis stabilization services for Medicaid beneficiaries. A 2018 CMS letter to State Medicaid Directors regarding “Opportunities to Design Innovative Service Delivery Systems” for individuals with serious mental health conditions points out that states “may be able to access administrative match for crisis call centers.”⁴⁹ This “administrative match” provides

federal Medicaid reimbursement for 50% of the proportion of the costs attributable to serving Medicaid beneficiaries. This administrative match is different from the federal medical assistance percentage (FMAP) that states receive for Medicaid covered services and therapies provided to Medicaid enrollees. For example, Georgia accesses federal Medicaid funding to help cover administrative costs associated with operating a modern statewide crisis system that includes a hotline with the capability for dispatching mobile crisis teams. The state demonstrates the proportion of costs attributable to Medicaid beneficiaries by estimating the percent of residents with serious mental illness, addiction, and intellectual disabilities/developmental disabilities who are enrolled in Medicaid since these populations are most likely to need crisis stabilization services.

In addition, some administrative costs can be reimbursed at a higher federal matching rate, under federal authorities that comprise the Medicaid Information Technology Architecture (MITA) according to the 2018 CMS guidance on Opportunities to Design Innovative Delivery Systems.⁵⁰ Under the MITA authorities, information technology costs can qualify for 90% federal match for implementation costs and 75% match for operating costs. The 2018 guidance specifically refers to this enhanced federal match under MITA as available “to help states establish crisis call centers to connect beneficiaries with mental health treatment as well as to develop technologies to link mobile crisis units to beneficiaries coping with serious mental health conditions.”⁵¹ In addition, according to this CMS guidance, “development by the state of data-sharing capabilities between hospitals and community-based mental health providers”⁵² regarding admissions and discharge for acute care may qualify for the enhanced MITA federal matching rates.

The 2018 CMS guidance also refers to the enhanced match under MITA being available for state development of telehealth-enabling technology. Furthermore, this guidance refers to state costs for developing electronic bed registries as qualifying for enhanced federal reimbursement of “90% for development costs and 75% for operational costs”.⁵³ Other examples of costs that may qualify for this higher match include providing cell phones or iPads to mobile crisis teams to facilitate telehealth services with a clinician at another location during a crisis intervention, developing and implementing software applications to facilitate communication between crisis call centers and supervisory clinicians with mobile crisis team staff, and implementing text and chat technologies that many beneficiaries, including younger people, may be more comfortable using as part of the services offered by crisis call centers.

States may also be able to use untapped Children’s Health Insurance Program (CHIP) funds for Health Services Initiatives (HSIs) focused on crisis stabilization services tailored to children and adolescents. HSI options allow states to use a limited amount of their annual CHIP allotments and receive the higher federal CHIP matching rate (generally about 15% percentage points higher than Medicaid for a state) for projects aimed at improving children’s health.⁵⁴ This spending is subject to the overall 10% cap on the use of CHIP funds for administrative purposes which must also account for spending to administer the CHIP funds.⁵⁵ A number of states use this source of flexible funding for projects related to behavioral health services, including suicide and violence prevention for lesbian, gay, bisexual, and transgender youth.⁵⁶ In addition, some states have used this funding to support development of poison control centers that provide emergency advice and referral assistance.^{57,58}

Existing Medicaid Authorities Support Coverage of Crisis Intervention and Stabilization Services

Medicaid is one of the largest sources of funding for mental health and substance use disorder services in the United States,⁵⁹ and many of the individuals who require crisis services are Medicaid beneficiaries. Therefore, Medicaid has a large role in determining access to behavioral health services including mental health and addiction crisis stabilization services. Practically, all state Medicaid programs do cover crisis intervention or stabilization services based on a variety of federal Medicaid authorities.⁶⁰

CMS directly addressed this topic in the guidance regarding “Opportunities to Design Innovative Services Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance.” That guidance pointed out that the following state plan benefits can authorize coverage of behavioral health crisis services: clinic services, diagnostic services, rehabilitative services, physicians’ services, other licensed practitioner services, as well as the health home benefit, and primary care case management.⁶¹ CMS specified that the services directly coverable with these authorities include screening, assessment, diagnosis, mental health and addiction treatment services, targeted case management, psychiatric rehabilitation services, peer supports, and family supports.

The 2018 Medicaid guidance further explained that some activities and costs that are key components of providing crisis stabilization services are not directly coverable. For example, provider costs for outreach and team supervision cannot be directly covered by regular Medicaid authorities. However, CMS explained that costs related to delivery of covered services may be incorporated into the reimbursement rates for the covered services.

Thus, in addition to providing comprehensive coverage of crisis intervention and stabilization services in their Medicaid programs, states should also ensure that their Medicaid reimbursement rate methodologies for crisis services incorporate the ancillary costs CMS pointed out as not directly coverable in the 2018 Medicaid guidance. These ancillary costs or activities include outreach and engagement with individuals in crisis and with other health care and public service providers as well as team coordination and supervision that are critical to crisis intervention and stabilization.

Furthermore, as the SAMHSA National Guidelines for Behavioral Health Crisis Care advised, reimbursement rates for crisis intervention and stabilization should take into account the need for these programs to be available at all times for unscheduled, emergency care similar to the rate structure for emergency department care and ambulance transports.⁶² The exigencies of providing crisis services that require providers to be available and on-call twenty-four hours a day seven days a week makes these types of programs difficult to finance using traditional fee-for-service or encounter-based methods.

Moreover, crisis stabilization reimbursement methodologies should allow for professional fees to be billed separately from the more inclusive team-based capacity rates for crisis stabilization. These professional fees can generally be billed to Medicare as discussed above; however, the team-based crisis stabilization rates most likely cannot. Therefore, separating out the professional fees can facilitate seeking Medicare reimbursement for those services. State agencies should ensure that services and consultations by higher credentialed providers via telehealth can be reimbursed as part of or as an adjunct to any team-based care payment methodology.

CMS has previously approved Medicaid payment methodologies and team-based capacity reimbursement rates sometimes paired with separately billed professional fees in a number of states. Below are examples of states that have implemented comprehensive team-based capacity reimbursement rates in their Medicaid programs:

- The New Jersey Medicaid program covers Psychiatric Emergency Rehabilitation Services (PERS) including mobile services for all Medicaid eligible consumers. Services include assessment, immediate crisis resolution and de-escalation, counseling, referral to appropriate services including arranging for transport or admission, consultation with physicians or other qualified providers, and follow-up as necessary with the individual and/or caretaker/family member within 14 days of an episode of PERS care. Reimbursements include an “episode of care” payment for mental health services provided by PERS certified assessors and PERS specialists. An episode of care must include at a minimum a comprehensive face-to-face assessment and a disposition with either a transfer or discharge. There are rates for the first 23.99 hours (including a higher rate for mobile crisis intervention) and an additional hourly rate for care that extends beyond 24 hours in a crisis intervention facility. Psychiatrists and other licensed professionals bill separately for time spent on direct therapy using the appropriate CPT codes. In addition, follow-up services are reimbursed per one-hour unit of service.⁶³
- Delaware covers mobile and facility-based crisis intervention services available 24 hours a day seven days a week to provide assessment, crisis stabilization and de-briefing with the beneficiary, crisis counseling, consultation with other qualified providers, psycho-education and supportive services for families and consumers, recovery/discharge planning, follow-up as necessary with the beneficiary and the beneficiary’s caretaker or family member, linkages to other services, and arranging for transfers, transport and admissions as necessary. Reimbursement for facility services is at a per diem rate, and mobile crisis services reimbursement rates are paid per 15-minute intervals.⁶⁴
- New York provides coverage of comprehensive crisis intervention services through its Medicaid managed care program as part of statewide effort to provide “a coordinated behavioral health crisis response system available to all New Yorkers”. The state has a comprehensive set of reimbursement rates that includes telephonic crisis response for 15-minute intervals and per diem rates for telephonic crisis responses that extend beyond 90 minutes. New York also has set rates for mobile crisis response in 15-minute intervals, per diem rates for mobile crisis interventions that last 90 to 180 minutes, and a different per diem rate for mobile crisis interventions that last for at least three hours. In addition, the state has set higher rates for teams of two with licensed professionals and unlicensed/certified peer support specialists. New York has also established reimbursement rates for crisis follow-up services in 15-minute intervals with different rates for single licensed providers and single peer providers and higher rates for two person teams comprised of a licensed provider and peer. New York is covering adult and child crisis residential services as part of this crisis intervention and stabilization program. The state has established suggested rates for crisis residential services for individuals over 21 and mandated rates for crisis residential services for individuals under 21.⁶⁵ New York’s benefit and bill guidance includes the following description of this benefit:

“The Crisis Residence component of the Crisis Intervention benefit is designed to reimburse providers to integrate Crisis Residence services into existing behavioral health crisis response systems. Crisis Residence programs are an important part of the statewide comprehensive crisis service continuum. These programs differ regionally according to local needs and resources. Crisis Residence programs work with community-based organizations, hospitals, schools, law enforcement, and other entities to address the needs of individuals experiencing a mental health crisis.”⁶⁶

The 2018 CMS guidance also pointed out that managed care authorities can support crisis stabilization services. Managed care arrangements can offer more flexibility regarding some restrictions in Medicaid and can include coverage of additional services not as directly covered by regular Medicaid authorities. Moreover, managed care organizations can facilitate use of multiple funding streams for crisis stabilization services including Medicaid reimbursement for services, MHBG and SAPTBG block grant funds and other federal grant funding, as well as state and local funds.⁶⁷

Importantly, state agencies should ensure that reimbursement rates for mobile crisis units are sufficient to support two person teams. The new mobile crisis intervention benefit in Medicaid discussed below requires at least two person teams for a mobile crisis service to qualify for an 85% federal match.

New Opportunities are Available in Medicaid to Support Crisis Stabilization Services and Systems

Medicaid programs in every state cover some form of crisis stabilization services using a variety of authorities and reimbursement approaches.⁶⁸ However, in a number of states there are still significant gaps in services covered (e.g., some states do not provide Medicaid reimbursement for mobile crisis services) and certain providers are excluded or limited in the types of services they can provide; for example, a number of states do not allow peers to participate in their Medicaid programs.⁶⁹ Furthermore, there are long-standing restrictions on the availability of Medicaid reimbursement for residential treatment settings with over 16 beds referred to as the Institutions for Mental Diseases (IMD exclusion).⁷⁰

The ARPA established two important new opportunities for states to increase support for crisis stabilization services in their Medicaid programs: an increased federal matching rate for qualifying mobile crisis intervention services and an increased federal match for home and community-based services (HCBS) including benefits covered under the Medicaid rehabilitative services, case management, and 1915(i) authorities.⁷¹

Requirements for Mobile Crisis Teams to Qualify for Increased Federal Medicaid Match

- Include at least two members
- Include one professional authorized to conduct an assessment (additional team member may be a peer)
- Be available 24/7 every day
- Be trained in trauma-informed care, de-escalation, and harm reduction
- Provide services outside hospitals or other facilities
- Be able to provide screening/assessment, stabilization, and coordination with health and social services and supports
- Have relationships with local medical and behavioral health providers

Increased Federal Medicaid Match for Mobile Crisis Stabilization Teams

Section 9813 in the ARPA incentivizes states to establish or expand Medicaid coverage for mobile crisis services with an 85% federal matching rate for covered services provided by qualifying mobile crisis units. This enhanced federal match is available for 12 quarters during the five-year period starting April of 2022. Qualifying mobile crisis services are defined as covered items and services that are furnished to a beneficiary outside a hospital or facility who is experiencing a mental health or substance use disorder crisis. These services must be provided by a multidisciplinary team that includes at least one behavioral health professional authorized to conduct an assessment of the individual under state law and other professionals or paraprofessionals with appropriate expertise in crisis response including peer support specialists. Members of these teams must be trained in trauma-informed care, de-escalation strategies, and harm reduction. These teams must be available 24 hours a day every day to provide screening and assessment, stabilization and de-escalation, and coordination and referrals to health, social, and other services and supports in a timely manner. To qualify for the enhanced match, states must provide assurances that they will use the additional federal funds to supplement and not supplant state funding for mobile crisis services based on the level of state funding during the prior fiscal year.

The ARP Act also appropriated \$15 million in planning grants to support development of state plan amendments, section 1115 demonstrations, or section 1915(b) or 1915(c) waivers to provide qualifying community-based mobile crisis intervention services. CMS issued the notice of funding opportunity for these planning grants on July 13, 2021.⁷² CMS included the following actions among the examples of activities for which planning grants could be used:

- “Technical assistance on planning emergent intervention and crisis services and the integration with crisis call centers, crisis intervention centers, and longer-term post-crisis care coordination programs and resources such as community-based recovery supports;
- Conducting a statewide needs assessment for community-based mobile crisis intervention services, including such factors as provider capacity, provider qualifications, scope of services furnished, equity strategies, and privacy protections;
- Enrolling prospective Medicaid providers and making technical assistance available for meeting Medicaid claiming requirements for furnishing community-based mobile crisis intervention services;
- Building linkages and developing collaborations of community-based mobile crisis intervention services with National Suicide Prevention Lifeline crisis call centers and first responders;
- Building and strengthening partnerships with relevant state and local partners (e.g., Single State Agencies for substance abuse and mental health); and
- Assessment of state information systems to identify options for improving interagency communication and data sharing for facilitating individuals’ access to on-going treatment and to prevent recurring crises”.⁷³

Ideally, these planning grants can support and encourage participation by state Medicaid agencies in statewide crisis services planning along with other crisis intervention stakeholders. These planning funds could encourage collaboration among these stakeholders on how Medicaid coverage policies can support broader availability of crisis stabilization services and how the MHBG and SAPTBG and other grant funding can be used to complement (instead of overlap) Medicaid coverage of crisis services including by covering fixed costs for establishing and operating mobile crisis teams. These collaborations could also explore other mechanisms for supporting crisis stabilization services including incorporating these services into coverage provided by Medicaid managed care plans as well as reimbursement rate methodologies for crisis stabilization services that take into account that these services must be available all the time and are accessed unpredictably on an emergency basis. In addition, this planning could include discussion of opportunities for expanded coverage and availability of crisis services presented by section 9817 of ARPA provision offering enhanced Medicaid funding for HCBS (discussed below).

Enhanced Federal Medicaid Funding for Home and Community-Based Services and Infrastructure

The ARPA includes another opportunity to increase Medicaid support for crisis stabilization services with section 9817 offering states a ten-percentage point increase in their federal matching rate for HCBS. This increased federal matching rate applies to state spending on HCBS from April 1, 2021 through March of 2022. State spending eligible for the enhanced federal match includes spending on benefits covered under a number of federal Medicaid authorities including the rehabilitative services benefit, the case management benefit, 1915(i) state plan option, and section 1115 demonstrations all of which often serve as the authorizing provisions for Medicaid coverage of crisis stabilization and other behavioral health services.

In recently issued guidance⁷⁴, CMS specifies that the additional federal funding amounting to 10% of a state's spending on HCBS from April 1, 2021 through March 31, 2022 must be used by the state on improvements or expansions of HCBS. These improvements or expansions can take place over a three-year period from April 2021 through March 31, 2024. The guidance further explains that this increased federal funding can be reinvested one time between April 1, 2021 and March 31, 2022 to cover the state share of additional HCBS *services* (the authorities for which are listed in Appendix B of the guidance).

There are two fundamental requirements for states to qualify for the additional federal funding for HCBS: 1) states must use the federal funds to supplement and not supplant state funding for HCBS; and 2) states must implement or supplement one or more activities to enhance, expand, or strengthen HCBS in their Medicaid program.

Regarding the first requirement, CMS guidance specifies that states may not impose stricter eligibility standards for HCBS than those in effect on April 1, 2021. In addition, states must maintain coverage of HCBS in effect as of that date including the services and amount, duration, and scope of that coverage. Finally, states must maintain provider payment rates for HCBS in effect as of April 1, 2021. These maintenance of effort requirements apply until the additional federal funds are fully expended.

Regarding the second requirement, CMS guidance advises that states must spend state funding equivalent to the increased federal matching funds to implement or supplement activities to enhance, expand, or strengthen HCBS. These activities must expand, enhance, or strengthen HCBS beyond what is available under the state Medicaid program as of April 1, 2021. State activities and spending to strengthen or expand HCBS can extend through March 31, 2024.

Several of the HCBS authorities listed in Appendix B of this guidance and eligible for the enhanced match and reinvestment are used by states to authorize Medicaid coverage of crisis stabilization services. Therefore, states could use this opportunity to significantly expand Medicaid coverage of crisis stabilization services authorized under the rehabilitative services option or case management authority or other HCBS authority in Appendix B with the additional federal funding provided by this provision of the ARPA. The guidance specifies that states may reinvest additional federal funding provided under this provision to cover the state matching funds for additional HCBS services and be eligible for the higher federal matching rates one time between April 2021 and March 2022.

In addition, many of the activities listed in Appendices C and D including those related to capacity building, infrastructure development, and improvements to reimbursement that states are encouraged to use these additional federal HCBS Medicaid funds on could be used by states to improve their crisis stabilization services and systems.

The CMS guidance explicitly recommends use of these federal HCBS funds for certain activities to improve mental health and substance use disorder services. This section specifically refers to skill rehabilitation to “assist eligible individuals in receiving mental health services, substance use treatment and recovery services, and necessary rehabilitative services” and expanding capacity including “recruiting additional behavioral health providers, increasing payment rates for providers, expanding access to telehealth.” Furthermore, although many of the other activities in Appendices C and D are framed as ways to expand and improve HCBS for people with physical or intellectual disabilities, these same types of activities could also help improve behavioral health crisis stabilization services. These other activities include --

- Increasing payment rates for care providers;
- Activities to recruit and retain care providers and professionals;
- Workforce training, technology costs (referring specifically to assistive technology, but could also include technology used to provide crisis services including iPads for law enforcement and/or mobile crisis teams and internet costs for new and/or expanded crisis stabilization centers);
- Educational materials (focused on COVID-19 but could also include 988 and telehealth);
- Language assistance including sign language (could also be implemented in crisis service systems to improve care for minority and underserved communities);
- Establishing toll free phone lines and marketing and outreach campaigns that could support 988 implementation;
- Providing person-centered planning and training (also critical for people experiencing a behavioral health crisis);
- Improvements to quality measurement;
- Developing cross-system partnerships among managed care plans, providers, and social support agencies including housing and employment supports;

- Caregiver training and respite, expanding the use of telehealth including investments in infrastructure including start-up costs, e.g., equipment, internet connectivity and activation costs, providing smartphones, and computers;
- Covering costs of implementing health information technology;
- Care coordination enhancements such as notification systems for hospital admission, discharge, and transfer notifications; and
- Implementing integrated care models.

All of these activities to enhance HCBS could be implemented by states specifically to improve and expand mental health and substance use disorder crisis stabilization services.

The guidance specifies that participating states are required to submit an initial spending plan estimating the total amount of federal funding the state plans to claim as the 10% federal match increase for HCBS. In addition, this plan must include a description of activities that the state will implement with these additional federal matching funds between April 1, 2021 and March 31, 2024. The guidance also points out that this plan should also explain how the state plans to sustain these activities beyond March of 2024. States also have to submit quarterly reports updating the estimates of the amount of federal funds the state expects to draw down due to the increased federal matching funds, any spending on the planned activities, and progress reports on those activities.

Moreover, the guidance also states that the initial and quarterly reports should include “any additional federal funds attributable to the increased federal match that the state expects to receive by reinvesting” the additional federal funds to cover the state share for additional HCBS services. As mentioned above, CMS did specify that the state must explain in their initial and quarterly reports how activities funded in this way will be sustained. As a result, use of some of this federal funding to cover fixed-cost infrastructure and capacity building activities may help lessen difficulty later on of maintaining expanded coverage of services.

A number of states have posted their plans for the use of this additional federal funding to expand and enhance HCBS. Some of these plans are fairly general and could support a variety of activities including activities to expand and improve crisis stabilization services. Moreover, some states indicate they plan to refine their plans in subsequent reports to CMS.

Massachusetts proposed to access an additional \$500 million in federal funding for HCBS under section 9817 of the ARPA.⁷⁵ The state has proposed to focus this funding on HCBS workforce, access, and technology/infrastructure improvements. In addition, the state’s plan indicates the additional federal funding will be used to support implementation of its “Roadmap for Behavioral Health Reform” issued in early 2021.⁷⁶ This Roadmap calls for a more centralized service enabling people to call or text to access mental health and addiction treatment and expanded availability of treatment including at night and on weekends, more community-based alternatives to emergency department crisis services, and more culturally relevant care. In addition, the state proposes an across-the-board payment increase and enhancements including hiring bonuses and internship and training opportunities for direct care workers. Furthermore, the state will invest in expanding access to HCBS services including Community Behavioral Health Centers and navigation supports in emergency departments and inpatient settings, as well as increased use of technology to improve communication, case management, coordination among

providers, data sharing, and caregiver directories. The state indicates it plans to further refine these plans going forward.

California's plan⁷⁷ proposes to draw down an additional \$4.6 billion in federal funding for HCBS. The state proposes to focus these funds on increasing and supporting HCBS direct care workers through training, stipends, bonuses, and career pathways. In addition, the state proposes use of these funds for improvements to transitions and navigation with HCBS including navigators in emergency rooms to screen and refer to mental health or SUD programs and services to assist individuals leaving criminal justice settings. The state proposes to use these funds to incentivize managed care plans to address homelessness. In addition, California proposes to use these funds for rehabilitation and construction of residential facilities for senior citizens. The state proposes to fund a contingency management pilot program for individuals with stimulant use disorder. In addition, the state proposes to fund several technology infrastructure projects focused on improving care for individuals with disabilities and senior citizens.

The Indiana plan proposes to use more than \$877 million in additional federal funding on HCBS workforce development, enhancing HCBS with specialized programs for different groups, building provider capacity, and caregiver training and support.⁷⁸ These proposed activities include investment in expanding the capability and capacity of the Indiana Crisis System based on the SAMHSA National Guidelines for Behavioral Health Crisis Care. These efforts will include support for one or more call centers with 24/7 call coverage. In addition, the state proposes to provide funding to behavioral health providers to expand mobile crisis support and crisis stabilization services.

Additional Avenues to Support Crisis Stabilization through Medicaid

In the 2018 Letter to State Medicaid Directors on "Opportunities to Design Innovative Service Delivery Systems for Adults with Serious Mental Illness or Children with Serious Emotional Disturbance", CMS highlighted increasing availability of crisis stabilization services as a key strategy for improving care for Medicaid beneficiaries with SMI or SED. This CMS guidance specifies that "[c]ore elements of crisis stabilization programs include development of regional or statewide crisis call centers coordinating access to care in real time, centrally deployed mobile crisis units available 24 hours a day seven days a week, and short-term, sub-acute residential crisis stabilization programs."⁷⁹ The letter also points out that these services can help divert Medicaid beneficiaries with these conditions from unnecessary stays in emergency departments and involvement with law enforcement.

Furthermore, this CMS guidance highlights that a long-standing prohibition on Medicaid reimbursement for services provided to beneficiaries residing in IMDs may apply to a core component of crisis stabilization systems, sub-acute crisis residential crisis stabilization programs, if those facilities have more than 16 beds. However, the letter describes how states may be able to cover these services for no more than 15 days under a Medicaid managed care rule that applies to comprehensive risk-based managed care organizations or prepaid inpatient hospital plans.⁸⁰

This State Medicaid Director letter also established a section 1115 demonstration initiative that waives the IMD exclusion to allow Medicaid coverage for crisis residential settings with over 16 beds in states that agree to take a number of steps to improve community-based behavioral health care in the state.

These additional actions referred to as “Milestones” in the guidance include committing to increased funding for community-based services including crisis call centers, mobile crisis units, and observation/assessment centers. As a result, this demonstration initiative frees up local and state funding previously dedicated to covering services in IMDs, so these funds can be used to support improvements in crisis intervention and stabilization programs.

States with these section 1115 demonstrations are also required to conduct in-depth annual assessments of the availability of mental healthcare throughout the state including the availability of the crisis stabilization services (including call centers, mobile crisis, and crisis stabilization centers). States are also required to provide updates on actions taken to increase availability of these services.

In addition, participating states are expected to report quarterly or annually on specific performance measures including emergency department utilization, inpatient utilization, and readmission following hospitalization in an inpatient psychiatric facility, follow-up after hospitalization for mental illness, access to preventive/ambulatory care, total costs, and per capita costs for mental health among beneficiaries in inpatient or residential setting compared to all other beneficiaries.⁸¹

As of July 2021, CMS has approved applications from the following states for these demonstrations: District of Columbia, Idaho, Indiana, Oklahoma, Utah, Vermont, and Washington. In addition, Massachusetts, Alabama, and New Mexico have submitted formal applications.

CMS previously established a similar section 1115 demonstration program in 2015 that was revised in 2017. This initiative likewise allows coverage of services for beneficiaries in IMDs including crisis residential settings primarily to receive SUD treatment. These demonstrations also require states to take a number of steps to improve the SUD treatment continuum of care in their state. In addition, states are required to report on a set of performance measures and metrics on a wide range of issues including the following topics: initiation and engagement in treatment, use of opioids, continuity of medication to treat opioid use disorder, treatment offered at discharge and follow-up after discharge, emergency department utilization, inpatient stays, and readmissions among beneficiaries with SUD. CMS has approved 32 states for these 1115 demonstrations and an additional three states have formally submitted applications.

These demonstrations incentivize states to enhance their crisis stabilization systems in order to meet the requirements or milestones to improve access to community-based care. In addition, statewide implementation of crisis stabilization services and the crisis system improvement activities discussed above should help states perform well on the milestones and performance measures for these demonstrations.

Telehealth is a Key Component of Enhanced Crisis Stabilization Services and Systems

Use of telehealth to provide mental health and addiction treatment services grew exponentially during the COVID-19 public health emergency. Almost 40% of Medicare beneficiaries accessed office visits via telehealth and 60% accessed mental health services via telehealth.⁸² Services delivered to Medicaid and CHIP beneficiaries via telehealth also increased dramatically particularly in the use of telehealth for mental health services.⁸³ In addition, commercial insurers greatly expanded coverage of telehealth, with private insurance claims data consistently showing mental health conditions to be among the most

frequent reason for telehealth visits. As utilization of telehealth overall has begun to decline, utilization of telehealth for mental health treatment has remained strong, far outpacing the level of continued use of telehealth for other conditions.⁸⁴

The availability of telehealth undoubtedly preserved access to behavioral healthcare to a significant degree. However, for many disadvantaged individuals, this alternative avenue was not sufficient to maintain access. Data recently released by CMS indicate that Medicaid enrollees' access to mental health and SUD services decreased dramatically during the pandemic and did not fully recover despite greater use of telehealth.⁸⁵ This decrease in utilization of behavioral healthcare was pronounced among children and youth during the pandemic perhaps due to the lack of access to behavioral healthcare through schools.⁸⁶

Crisis call centers, mobile crisis service providers, and crisis stabilization centers often provide services via telehealth. Continued expanded coverage of telehealth with reimbursement rates on par with in-person services will help support broader availability of crisis services that can hopefully address some of the behavioral health impact and expected increased need for mental health and SUD treatment services resulting from the Covid-19 pandemic.

The significance of expanded Medicare coverage of telehealth services for improving access to crisis stabilization services should not be overlooked since Medicare coverage policies often influence Medicaid and commercial insurance. Moreover, continued coverage of audio-only telehealth services will be critical since telehealth crisis services are often provided via telephone calls. Among Medicare beneficiaries who had a telehealth visit last summer and fall, over half of them accessed care using a telephone only.⁸⁷ Furthermore, coverage of audio-only telehealth services enables access to behavioral healthcare in areas where broadband service is often not available to support video interactions. Low-income populations and homeless individuals are also less likely to have access to telehealth services via video-conference technology.

In addition, availability of care through audio-only telehealth is even more important in rural areas due to the common shortage of behavioral healthcare providers in those areas. According to the Health Resources and Services Administration (HRSA), there are more than 5,700 mental health provider shortage areas across the United States, with more than one-third of Americans (119 million people) living in these shortage areas.⁸⁸ Telehealth services can help extend the capacity of behavioral health services to reach individuals in need of behavioral healthcare including crisis services in those shortage areas.

Recent legislation has significantly improved Medicare coverage of telehealth for beneficiaries in need of mental health or substance use disorder treatment. The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT Act)⁸⁹ improved Medicare coverage of telehealth for SUD treatment by eliminating the limitation on coverage to services provided in certain rural geographic areas and the requirement that beneficiaries travel to originating site facilities to access telehealth services. (Currently, CMS has waived these limits on telehealth during the pandemic.) Due to this change in the law, even after the public health emergency is over, Medicare beneficiaries will be able to access SUD services via telehealth from their homes or communities and regardless of the geographic area they are in. Furthermore, these changes also require that reimbursement for providers be at the same rate as if these services were provided in-person, although facility fees would not be provided.⁹⁰

Similar improvements to Medicare coverage of mental health services via telehealth to beneficiaries at home and regardless of geographic locations were enacted as part of the CAA.⁹¹ In addition, in a recent rulemaking implementing this provision, CMS has also proposed to maintain Medicare coverage of audio-only technology for telehealth services for mental health and certain SUD treatment.⁹² These changes could help support Medicare coverage of telehealth services provided by crisis stabilization services providers, but a requirement that the beneficiary must have seen the provider in-person within the prior six months is a significant barrier to the utility of these provisions for improving access to crisis stabilization services. Exceptions to this preexisting treatment relationship requirement should be allowed for behavioral health crisis situations.

Opportunities to Support Crisis Stabilization through Alternative Payment Models and Demonstrations

As discussed above, reimbursement for crisis stabilization services must be structured differently than payment for other mental health or substance use disorder services. Payment methodologies and rates must take into account the need to have crisis stabilization services available around the clock and accessible without appointments or even notice. These services also generally require a team-based approach to care that is sometimes provided in the community by a mobile crisis unit, sometimes in a crisis receiving/observation center, and sometimes an emergency room or other setting, including jails. These types of services demand a flexible funding approach that factors in the variety of resources needed to provide this type of care.

Certified Community Behavioral Health Clinic Model

The Medicaid CCBHC demonstration is one example of how a comprehensive flexible payment methodology can be developed that includes mobile crisis services in the community as well as crisis stabilization services in a clinic setting. This demonstration supports provision of a comprehensive array of services by community mental health centers with a cost-based daily or monthly Medicaid payment rate. The Medicaid demonstration was the basis for the CCBHC expansion grants described above that were increased substantially in the CAA and ARPA. There are also quality improvement features included in the demonstration. States have the option to provide bonus payments to CCBHCs that meet certain quality metrics. In addition, CCBHCs and states are required to report on performance measures aimed at assessing the impact of this demonstration. The demonstration includes 10 states.⁹³ It started in 2016 and has been extended many times most recently until September 30, 2023.

Several of the Medicaid CCBHC demonstration states have added their CCBHC payment rates to their Medicaid state plans. In Missouri, for example, the state plan amendment adding this payment rate for clinics that qualify as CCBHCs refers to the Rehabilitative Services Option for authority. This payment methodology incorporates all the costs of providing 24/7 crisis stabilization services including mobile crisis services and also including the costs of activities that go into providing these services that are not as directly covered by existing Medicaid authorities including outreach and engagement costs, care coordination, and team-based consultation costs.

In addition to this Medicaid demonstration, the CCBHC expansion grant program has funded development of CCBHCs in all but about ten states.⁹⁴ These grants do not include the Medicaid

reimbursement model incorporated into the demonstration. However, availability of CCBHCs in a state, even those that are funded by SAMHSA discretionary grants, could facilitate development of a Medicaid payment rate modeled after the payment rates in the CCBHC demonstration that could cover all the costs that go into providing 24/7 crisis stabilization services.

Emergency Triage, Treat, and Transport (ET3) Model

The Center for Medicare and Medicaid Innovation (CMMI) within CMS recently kicked off a new payment model for emergency services for Medicare beneficiaries that is closely aligned with the objectives of increasing crisis stabilization services.⁹⁵ This model, the Emergency Triage, Treat and Transport (ET3) model, pays for transportation of Medicare beneficiaries to alternative locations instead of the settings to which beneficiaries are generally required to be brought, usually hospital emergency departments. Participants in the five-year program that started in January of 2021 are 184 public and private Medicare-enrolled ambulance providers in 36 states. The model will test two new Medicare payments: 1) for ambulance transport to alternative destinations not currently covered by Medicare; and 2) for treatment in place when appropriate by a qualified health care practitioner at the scene of an emergency response or via telehealth. The alternative settings where participating ambulance providers may bring beneficiaries include primary care offices, urgent care clinics, and community mental health centers or other destinations approved by CMS. Crisis stabilization centers should also qualify as alternative settings where Medicare beneficiaries could be brought. Payments to participants will be tied to performance on key quality measures in the third year of the demonstration.

This nationwide demonstration highlights the need for alternatives to emergency departments for those who do not really need to be there, and the need for greater flexibility in state and federal regulations regarding emergency response and where individuals experiencing a behavioral health crisis may be brought for stabilization services. In addition, this demonstration points out the need for improvements to Medicare coverage of crisis stabilization services. As described above, Medicare coverage for crisis stabilization services is generally limited to crisis psychotherapy (CPT codes 90839 and 90840), but many crisis stabilization centers do not bill for these codes because they do not have the staff with the right credentials.

CMMI also announced a complementary opportunity for local governments where emergency transport providers participating in the ET3 model are located. This additional opportunity will provide funding to expand emergency and non-emergency medical triage services in these locations. As currently structured, access to triage services funded with these grants would have to be provided in response to calls to 911. However, there may be an opportunity to coordinate these improved triage capacities with broader state and local efforts to increase the availability of triage services for callers to 988. State mental health and substance use disorder agencies should identify whether any of the providers in their state are participating in this program⁹⁶ and incorporate those activities into their planning for coordinated and comprehensive crisis stabilization systems.

CMMI in collaboration with the Center for Medicaid and CHIP Services at CMS issued guidance on how states could implement similar payment and care delivery models in their Medicaid programs.⁹⁷ This guidance describes various Medicaid authorities and payment policies that states could implement in order to support emergency transport for Medicaid beneficiaries to alternative destinations instead of

emergency departments and to cover practitioners including EMTs providing services to Medicaid beneficiaries on the scene of a 911 response.

This joint guidance points out that under federal law Medicaid may cover emergency response services provided on the scene without transport by EMTs who are under the supervision of a physician or other licensed practitioners including licensed paramedics. In addition, Medicaid may cover services provided on the scene by unlicensed practitioners under the preventive services Medicaid authority although these services must be recommended by and under the supervision of a licensed provider. This guidance could be useful in considering how to structure Medicaid coverage of mobile crisis teams.

In addition, the joint guidance points out some issues for states to consider in implementing Medicaid coverage of crisis stabilization services including whether state policies and regulations prohibit emergency response personnel from transporting individuals to alternative destinations or prohibit providing treatment on the scene of the emergency without providing transportation. In addition, the guidance encourages states to consider whether the state Medicaid program covers the relevant HCPCS codes for emergency response services.

In this guidance, CMS points out that federal Medicaid law and regulations do not specify that emergency transportation must be to a hospital and indicates that these issues are determined in state law and regulation. CMS also specifies that a number of state Medicaid agencies have implemented Medicaid coverage of transportation to alternative destinations and CMS lists crisis stabilization centers as examples of alternative destinations that state Medicaid agencies may include in their initiatives. CMS also highlights that Medicaid managed care plans may have flexibility to cover alternative destinations and transportation services.

Partnerships with Hospitals and Health Systems: The Maryland Example

Maryland has a unique approach to healthcare financing that may be instructive for how to encourage greater collaboration between hospitals and community-based providers on development of crisis stabilization programs and services. The Health Services Cost Review Commission (HSCRC) sets the reimbursement rates that all payers (e.g., Medicare, Medicaid, commercial) must pay hospitals in the state. This program required a waiver from the Centers for Medicare and Medicaid Services so that Medicare could be included in this all-payer initiative.⁹⁸ The most recent renewal of this waiver agreement between Maryland and CMS requires the state to meet certain benchmarks regarding care for Medicare beneficiaries in the state in terms of spending and performance measures. To keep control over spending for Medicare beneficiaries in the state, the HSCRC has offered grant funding for regions and localities in the state to support development of collaborations between hospitals and community-based providers to help drive down spending while increasing quality of care. A recent round of grants focused on supporting development of crisis stabilization systems in different regions within the state with the hope that these efforts will result in establishment of programs that offer individuals experiencing behavioral health crises alternatives to going to the hospital emergency departments.⁹⁹ Hospitals are key stakeholders in efforts to develop crisis stabilization facilities and programs as alternatives to emergency departments, and states are encouraged to coordinate with them in efforts to improve crisis stabilization systems and increase availability of crisis stabilization programs and services.

Conclusion

The dual national crises of increased drug overdoses and high rates of suicide demand a new approach to addressing behavioral health crises. Designation of 988 as a nationwide toll-free hotline is a galvanizing event that should spur renewed focus on developing comprehensive coordinated crisis stabilization systems that can respond to the needs of 988 callers with local resources and support. Fortunately, several game-changing opportunities have arisen to help support state and local efforts including tremendous increases in federal block grant funding, a number of opportunities to enhance Medicaid funding for these programs, and greatly expanded coverage of telehealth services.

Recommendations for State Policy Makers Regarding Increased Block Grant and Medicaid Funding

I. Invest in Statewide Crisis Stabilization Systems

- Develop and coordinate statewide improvements to crisis stabilization programs by convening stakeholders with vested interests in increasing access to these services in addition to state mental health and substance use disorder agencies including state Medicaid agency leaders, law enforcement, hospital/health system emergency departments, crisis stabilization services providers, insurance commissioners, emergency transportation providers, 911 operators, other hotline and public service number operators, housing authorities, people with lived experiences of having serious behavioral health conditions, peer support specialists, families of adults or children with serious behavioral health conditions, representatives of underserved communities and populations, as well as possibly other state and local regulatory agencies that regulate providers of emergency services;
- Conduct a gap analysis regarding capacity of existing crisis stabilization centers, mobile crisis teams, and call centers and assess the need for increased capacity and coordination among these programs;
- Enhance health information technology including by expanding broadband, providing technology for telehealth, and improving or establishing electronic systems for tracking which providers have capacity to care for individuals in crisis;
- Pursue Medicaid funding for state administrative costs, including enhanced match for health information technology, for improving crisis stabilization systems and services including development and operation of call centers and electronic systems for tracking crisis stabilization programs' capacity to accept individuals in crisis, as well as support for improvements to providers' telehealth capabilities (in proportion to the degree to which Medicaid enrollees benefit from these improvements);
- Consider funding call center operations through contracts to support rapid responses regardless of coverage;
- Develop protocols for when responses to hotline calls should come through 911 or 988 as well as policies for when and how law enforcement should be involved in crisis response activities;
- Remove state limitations on coverage of interventions provided outside of hospitals;
- Eliminate restrictions on emergency transportation only to hospital emergency departments to allow reimbursement for transportation to crisis centers, clinics, and other settings;
- Explore whether CHIP funding for HSIs is available to support development of specialized crisis stabilization services for children and adolescents; and
- Develop data collection and quality assurance programs for crisis stabilization programs;

II. Improve Coverage of Crisis Services and Provider Reimbursement to Increase Availability of Stabilization Programs

- Reconsider how crisis stabilization services are financed to determine whether additional Medicaid authorities are available for covering crisis services;
- Access additional federal Medicaid funding through the 10% increased federal match rate for HCBS to improve and expand crisis stabilization programs;
- Revise Medicaid reimbursement rates for crisis stabilization programs to address the need for team-based capacity that is available around the clock and allow professional fees to be billed separately from the team-based payment in part to facilitate reimbursement by other payors including Medicare;
- Ensure Medicaid reimbursement rates for mobile crisis stabilization services are sufficient to support two-person teams;
- Add coverage of peer supports to the state Medicaid program, if not already covered, and authorize peers support providers to support clinicians in providing crisis stabilization services;
- Develop and submit a state plan amendment or other authorization to access the 85% federal Medicaid match to expand mobile crisis services beginning April of 2022;
- Ensure coverage of telehealth for behavioral health services including audio-only telehealth with comparable reimbursement rates to in-person treatment in Medicaid and state-regulated insurance;
- Authorize and support billing by call center staff for telehealth services provided to callers;
- Require health insurers offering coverage plans in the state, including Medicaid managed care plans, to cover crisis stabilization services and include crisis stabilization providers in their networks; and
- Apply for section 1115 demonstrations for innovative service delivery systems for individuals with SUD, SMI, or SED to expand coverage of crisis residential settings that qualify as IMDs;

III. Support Providers to Expand Access to Crisis Stabilization Services

- Cover providers' start-up costs for establishing new crisis stabilization programs including hiring staff and developing capacity to bill Medicaid, commercial insurance, and Medicare;
- Work with crisis services providers to improve their capacity to bill Medicare and commercial insurance, as well as Medicaid, for covered crisis services;
- Encourage hiring of peer support specialists particularly by crisis stabilization programs, and incentivize development of stepped up career opportunities for peers;
- Reexamine limits on scope of services for providers of crisis stabilization services to ensure they are not unnecessarily restrictive;
- Support provider establishment of crisis stabilization programs to address the needs of special populations with flexible funding for start-up costs and training; and
- Provide training for providers and other crisis stakeholders regarding crisis responses for special populations including children with serious behavioral health conditions, underserved and minority communities, and individuals with IDD.

Recommendations for Additional Federal Policies to Support Crisis Stabilization Systems and Programs

- Establish a permanent ten percent set-aside in the MHBG to support on-going crisis stabilization system expansions and improvements;
- Provide infrastructure funding to states and counties to cover construction of new crisis stabilization facilities;

- Clarify that the IMD exclusion does not apply to crisis stabilization centers because they are focused on providing short-term de-escalation and stabilization and connections to treatment as opposed to being “primarily engaged in providing diagnosis, treatment, or care for persons with mental diseases”;¹⁰⁰
- Require Medicare Advantage, Qualified Health Plans, and Federal Employee Health Benefit Program plans to cover crisis stabilization services;
- Maintain Medicare coverage of telehealth, including audio-only services, with reimbursement on par with rates for in-person services;
- Recognize an exception for behavioral health crises to the Medicare telehealth requirement that the beneficiary must have seen by the provider in-person within the prior six months for Medicare to cover mental health or substance use disorder telehealth services to beneficiaries who are home or in their communities;
- Issue federal guidance on application of parity to crisis stabilization services; and
- Encourage and enable CMMI ET3 model participants to coordinate emergency response activities covered by Medicare through that demonstration with efforts to improve responses to 988 in those communities.

SIGNIFICANT DATES

April 2022: Medicaid 85% federal Match for mobile crisis services goes into effect for twelve quarters

JULY 2022: Three-digit behavioral health crisis and suicide prevention hotline, 988, available nationwide via all telecommunications providers

MARCH 2023: Deadline for states to expend additional MHBG and SAPTBG funding provided in the CAA

MARCH 2024: Deadline for states to spend 10% increase in federal Medicaid match for HCBS

SEPTEMBER 2025: Deadline for states to expend additional MHBG and SAPTBG funding provided in the ARPA

List of Abbreviations

ARPA	American Rescue Plan Act
CCBHC	Certified Community Behavioral Health Clinic
CHIP	Children’s Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CAA	Consolidated Appropriations Act, 2021
ET3	Emergency Triage, Treat, and Transport
IDD	Intellectual or Developmental Disabilities
IMD	Institution for Mental Diseases
MHBG	Community Mental Health Services Block Grant
SAMHSA	Substance Abuse and Mental Health Services Administration
SAPTBG	Substance Abuse Prevention and Treatment Block Grant
SMI	Serious Mental Illness
SUD	Substance Use Disorder

NB: The author would like to thank Brenda Jackson for her detailed input and expert guidance.

Appendix A: SAMHSA Guidance on Mental Health Block Grant Set-Aside for Crisis Services

Guidance for the revision of the FY 2020-2021 Mental Health Block Grant Application for the new Crisis Services 5% set-aside

Substance Abuse and Mental Health Services Administration (SAMHSA) is directed by Congress through the Consolidated Appropriations Act, 2021 and the Coronavirus Response and Relief Supplement Appropriations Act, 2021 [P.L. 116-260], to set aside 5 percent of the Mental Health Block Grant (MHBG) allocation for each state to support evidence-based crisis systems. Congress specifically provided an increase to federal fiscal year (FY) 2021 MHBG appropriation over the FY 2020 level to help states meet this new requirement without losing funds for existing services. The appropriation bill has the following requirement for the new 5 percent set-aside.

Furthermore, the Committee directs a new five percent set-aside of the total for evidence-based crisis care programs addressing the needs of individuals with serious mental illnesses and children with serious mental and emotional disturbances. The Committee directs SAMHSA to use the set-aside to fund, at the discretion of eligible States and Territories, some or all of a set of core crisis care elements including: centrally deployed 24/7 mobile crisis units, short-term residential crisis stabilization beds, evidence-based protocols for delivering services to individuals with suicide risk, and regional or State-wide crisis call centers coordinating in real time.

A fully developed crisis response system is responsive any time and any place. What does a person in crisis need? Someone to talk to, or someone to respond, or a safe place to go for evaluation, stabilization and follow up. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-intervention and response systems. SAMHSA recognizes that the development of fully accessible and responsive crisis services involves complex problem solving with multiple entities and systems. We also recognize that strategic crisis services implementation can result in better care and cost savings through the reduction in avoidable emergency department visits, psychiatric admissions, police engagement, arrests, incarcerations and 911 calls.

SAMHSA recently developed [Crisis Services: Meeting Needs, Saving Lives](#), which includes [“National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit”](#) as well as other related National Association of State Mental Health Program Directors (NASMHPD) papers on crisis services. Please note that this set aside funding is dedicated for the core set of crisis services as directed by Congress. Nothing precludes states from utilizing more than 5 percent of its MHBG funds for crisis services for individuals with serious mental illness or children with serious emotional disturbances. If states have other investments for crisis services, they are encouraged to coordinate those programs with programs supported by this new 5 percent set aside. This coordination will help ensure services for individuals are

swiftly identified and are engaged in the core crisis care elements.

SAMHSA is requesting states to implement this 5 percent set-aside through a “request for revision of the 2020-21 MHBG plan” within the Environmental Factors, Section 15. Crisis Services. States are encouraged to fund programs to meet the needs of persons with crisis services, specifically utilizing the SAMHSA’s *National Guidelines for Behavioral Health Crisis Care*, tool kit. States may address the three core services either through enhancing existing program activities or through developing a set of new activities based on the tool kit.

It is expected that the states’ capacity to implement crisis services will vary based on the actual funding from the 5% allocation. It is also recognized that with the timing of the allocation distribution, states may need to dedicate the rest of the current fiscal year to planning, training, and/or infrastructure development while targeting program implementation to the following year. Additionally, many states have begun implementing such models or similar approaches and can build on these existing efforts through their proposed MHBG plan revision. States must submit their plan revision request proposal into the FY 2020-2021 MHBG Behavioral Health Assessment and Plan in Section C. Environmental Factors and Plan, 15. Crisis Services. This section initially requested to report how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from crises.

States should also complete line 10, Crisis Services (5%) in Table 2 State Agency Planned Expenditures [MH] under Section B: MHBG.

SAMHSA requests states to submit the following with the proposal.

- Update the checkboxes and add any comments in the comment boxes in Section C. Environmental Factors and Plan, 15. Crisis Services
- Update Table 2 to reflect the 5% set-aside funds

Include a description of the current status of your states crisis program as well as proposed plan for expenditure of the 5% set aside. We recommend the following information when submitting the proposals.

- Description of the status of the state’s current crisis system. Please describe in terms of the following three elements: current access to local crisis call centers, the availability of mobile crisis behavioral health first responder services and the availability and or utilization of short-term crisis receiving and stabilization centers. The suggested framework for describing your states current system capacity is below. Receipt of this data will enable us to track national development and utilization of each of the crisis components over time.
- Stages of Implementation terms:
 - a) The ***Exploration-Planning*** stage: is the stage when states identify their communities’ needs, assess organizational capacity, identify how crisis services meet community needs, and understand program requirements and adaptation.

b) The **Installation** stage: occurs once the state has proposed a plan and begins making the changes necessary to implement the service based on the SAMHSA guidance.

This includes coordination, training and community outreach and education activities.

c) **Early Implementation**: occurs when the state has the core crisis service implemented in some parts of the state, about 25% or less persons have access to that service.

d) **Middle Implementation** stage: occurs when the state has the core crisis service implemented such that about half of the people in your state have access to that service.

e) **Majority Implementation**: occurs when the state has the core crisis service implemented in most parts of the state so that most people have access.

f) **Program Sustainment** stage: occurs when implementation is statewide and has a clear funding plan.

We request that you indicate what stage each of the three elements is in your state and submit this back to us in your application.

	Exploration Planning	Installation	Early implementation Less than 25% of people in state	Middle Implementation About 50% of people in state	Majority Implementation At least 75% of people in state	Program Sustainment
Someone to talk to						
Someone to respond						
Place to go						

Other program implementation data that might be useful to characterize crisis services system development. These are included for your consideration only and we recognize that some of these are not readily available. These are based on data components that some states and localities have found useful in measuring impact and outcome of crisis services.

1. Someone to talk to: Call Center Capacity
 - a. Number of locally based crisis call Centers in state
 - i. In the Suicide lifeline network
 - ii. Not in the suicide lifeline network
 - b. Number of Crisis Call Centers with follow up Protocols in place
 - c. Total number of calls statewide and by local crisis call center
 - d. Percent of 911 calls that are identified as MH related

2. Someone to respond: mobile behavioral health crisis capacity
 - a. Number of mobile responders that are independent of first responder structures (police, paramedic, fire)
 - b. Number of mobile responders that are integrated with first responder structures (police, paramedic, fire)
 - c. Number of mobile responders that employ peers
 - d. Number of police responses to mental health crises
3. Place to Go: Available resources in the state
 - a. Number of Emergency Departments
 - b. Number of Emergency Departments that operate a specialized behavior health component.
 - c. Number of Crisis Receiving and Stabilization Centers (short term, 23 hr units that can diagnose and stabilize individuals in crisis)
 - d. Number of hours of overtime by law enforcement related to accompaniment of persons with MH conditions in ED or other settings.
 - e. Number of persons boarded in ED (In ED longer than 24 hours and waiting for psychiatric admission.)
- Clearly describe the proposed/planned activities utilizing the 5% set aside for FY 21, including an estimated budget. States may be at different stages for different geographic locations. States will be required to report on what activities have been completed throughout the grant with this set-aside funding.
- Via the revision request, upload the document (word or pdf) using the upload tab into Section C. Environmental Factors and Plan, 15. Crisis Services. Please title this document “Crisis Services in FY 21”. Upon submission, SAMHSA will review the revision proposals to ensure they are complete and responsive. Once the revision proposal is approved by SAMHSA, the allotment for the 5 percent set aside will be awarded to the state.

Appendix B: SAMHSA Guidance on American Rescue Plan Act Funding



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May 18, 2021

Dear Single State Authority Director and State Mental Health Commissioner:

Public Law 117-2, the American Rescue Plan Act of 2021 (ARPA), signed by President Biden on March 11, 2021, directed the Substance Abuse and Mental Health Services Administration (SAMHSA) to provide additional funds to support states through Block Grants to address the effects of the COVID-19 pandemic for Americans with mental illness and substance use disorders. The COVID-19 pandemic has exposed and exacerbated severe and pervasive health and social inequities in America, including the critical importance of supporting people with mental illness and substance use disorders. As the pandemic swept through the states, societal stress and distress over this newly emerging disaster created the need for nimble and evolving policy and planning in addressing mental and substance use disorder services. SAMHSA, through this guidance, is asking states to improve and enhance the mental health and substance use service array that serves the community.

ARPA allocated \$1.5 billion each for Mental Health Block Grant (MHBG) and Substance Abuse Prevention and Treatment Block (SABG) grants to the states. States have until September 30, 2025, to expend these funds. Federal block grant monies are provided to support state priorities and SAMHSA asks that states consider the following in developing an ARPA Funding Plan.

A. MHBG Guidance

States must spend the MHBG funds based on 42 U.S.C. Chapter 6A, Subchapter XVII, Part B, Subpart I: Block Grants for Community Mental Health Services for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). Consistent with HHS Disaster Relief Flexibilities, SAMHSA may waive requirements with respect to allowable activities, timelines, or reporting requirements for the MHBG, as deemed necessary to facilitate a grantee's response to coronavirus.

The MHBG allocation requires states to set aside ten percent (10%) of their total allocation for first-episode psychosis or early SMI programs.

SAMHSA encourages states to consider a focus on support of a behavioral health crisis continuum. An effective statewide crisis system affords equal access to crisis supports that meet needs anytime, anyplace, and for anyone. This includes those living in remote areas and underserved communities as well as youth, older adults, persons of diverse backgrounds, and other marginalized populations; the crisis service continuum will need to be able to equally and adeptly serve everyone. SAMHSA recommends states consider use of the ARPA MHBG funds to develop, enhance, or improve the following:

- Develop partnerships with the emerging Suicide Lifeline (9-8-8) systems, Law Enforcement, EMS, health care providers, housing authorities, Housing and Urban Development (HUD) Continuum of Care, hospital systems, peer-based recovery organizations, and substance use specific treatment providers, all of whom have a critical role in the crisis continuum.
- Utilize five percent of funds for crisis services, as described in the FY 2021 appropriations language.
- A comprehensive 24/7 crisis continuum for children including screening and assessment; mobile crisis response and stabilization; residential crisis services; psychiatric consultation; referrals and warm hand-offs to home- and community-based services; and ongoing care coordination.
- Provide increased outpatient access, including same-day or next-day appointments, for those in crisis.
- Improve information technology infrastructure, including the availability of broadband and cellular technology for providers, especially in rural and frontier areas; use of GPS, to expedite response times, and to remotely meet with the individual in crisis.
- The adoption and use of health information technology, such as electronic health records, to improve access to and coordination of behavioral health services and care delivery.
- Consider digital platforms, such as Network of Care, which facilitate access to behavioral health services for persons with SMI-SED.
- Advance telehealth opportunities to expand crisis services for hard to reach locations, especially rural and frontier areas. Expand technology options for callers, including the use of texting, telephone, and telehealth. Note: States cannot use the funds to purchase any items for consumers/clients.
- Implement an electronic bed registry that coordinates with existing HHS provider directory efforts and treatment locator system that will help people access information on crisis bed facilities, including their locations, available services, and contact information.
- Support for crisis and school-based services that promote access to care for children with SED.
- Develop medication-assisted treatment (MAT) protocols to assist children and adults who are in crisis, which may leverage telehealth when possible.
- Expand Assisted Outpatient Treatment (AOT) services.
- Develop outpatient intensive Crisis Stabilization Teams to avert and address crisis.
- Technical Assistance for the development of enhanced treatment and recovery support services including planning for Certified Community Behavioral Health Clinics (CCBHC).

SAMHSA requests that the following information is included when submitting the proposals:

1. Identify the needs and gaps of your state's mental health services continuum including prevention, intervention, access to crisis services, treatment, and recovery support services.

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2. Identify the needs and gaps of your state’s mental health services related to developing a comprehensive crisis continuum. Focus on access to your states services through crisis call centers with local knowledge of available services, availability of mobile crisis response teams and crisis receiving and stabilization services.
 3. Describe your state’s spending plan proposal, including a budget that addresses the needs and gaps related to crisis and services continuum.
 4. Describe how the state will advance the development of crisis and other needed prevention, intervention, treatment and recovery support services so that your state’s system is responsive to the needs of your residents with SMI and SED. Refer to the [Guidebook](#) on crisis services.
 5. Explain how your state plans to collaborate with other departments or agencies to address crisis, treatment, and recovery support services.
 6. Describe how the state plans to spend the ten percent set aside for first-episode psychosis/early SMI and, if applicable, the five percent set aside for crisis services.
 7. Describe other state priorities or activities that the state plans to fund during the performance period using ARPA funds, with consideration given to disproportionately high rates of MH/SUD in certain communities and disparities in COVID-19 BH-related outcomes by race, ethnicity, and other factors.
 8. Describe how the state will use, or consider, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification [criteria](#) in health IT products used or that will be used to support behavioral health clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (<https://www.healthit.gov/isa/>), including but not limited to those standards described in the, the “Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data” section and the “Social Determinants of Health” section.

Using the WebBGAS Revision Request for the FFY 2021 Block Grant Application, upload the document (Microsoft Word or pdf) using the tab into the State Information Section, Chief Executive Officer’s Funding Agreement – Certifications and Assurances/Letter Designating Signatory Authority [MH]. Please title this document “ARPA Funding Plan 2021 (MH).”

B. SABG Guidance

States are required to plan for, expend, and report on the FY 21 SABG ARPA Supplemental Funding based on 42 U.S.C. Chapter 6A, Subchapter XVII, Part B, Subpart II: Block Grants for Prevention and Treatment of Substance Abuse, and 45 CFR, Part 96, Subpart L.

Consistent with HHS Disaster Relief Flexibilities, SAMHSA may waive requirements with respect to allowable activities, timelines, or reporting requirements for the SABG as deemed necessary to facilitate a grantee’s response to coronavirus.

Accordingly, all regular provisions of the statute and regulations pertaining to the SABG are fully applicable to the planning and expenditure of the SABG ARPA Supplemental Funding.

This includes, but is not limited to, the definitions, assurances, requirements, and restrictions of the SABG standard funding.

The SABG allocation requires states to expend not less than twenty percent (20%) of their total allocation for substance use disorder (SUD) primary prevention services for individuals who do not require treatment for substance abuse, in accordance with 42 USC 300x-22 and 45 CFR 96.124 and 96.125. The SABG allocation also requires “designated states” to expend five percent (5%) of their total allocation for EIS/HIV Services, in accordance with 42 USC 300x-24(b) and 45 CFR 96.128.

The SUD prevention, intervention, treatment, and recovery support services continuum includes various evidence-based services and supports for individuals, families, and communities. Integral to the SABG are its efforts to support health equity through its priority focus on the provision of SUD prevention, treatment, and recovery support services to identified underserved populations. These underserved and marginalized populations include, but are not limited to, pregnant women and women with dependent children; persons who inject drugs; persons using opioids and/or stimulant drugs associated with drug overdoses; persons at risk for HIV, TB, and Hepatitis; persons experiencing homelessness; persons involved in the justice system; persons involved in the child welfare system; Black, Indigenous, and People of Color (BIPOC); LGBTQ individuals; rural populations; and other underserved groups.

SAMHSA recommends states develop, enhance or improve the following through the SABG ARPA funds:

- Develop and expand the use of FDA-approved medications and digital therapeutics as a part of addiction treatment that can provide interactive, evidence-based behavioral therapies for the treatment of opioid use disorders, alcohol use disorders, and tobacco use disorders, along with the implementation of other evidence-based treatments and practices.
- Provide increased access, including same-day or next-day appointments, and low barrier approaches, for those in need of SUD treatment services.
- Direct critical resources in expanding broad-based state and local community strategies and approaches in addressing the drug overdose epidemic, involving SUD prevention, intervention, treatment, and recovery support services.
- Improve information technology infrastructure, including the availability of broadband and cellular technology for providers, especially in rural and frontier areas, and use of GPS to expedite response times and to remotely meet with the individual in need of services.
- The adoption and use of health information technology to improve access to and coordination of SUD prevention, intervention, treatment, and recovery support services and care delivery, consistent with the provisions of HIPAA and 42 CFR, Part 2.
- Advance telehealth opportunities to expand services for hard-to-reach locations, especially rural and frontier areas. Expand technology options for callers, including the use of texting, telephone, and telehealth. Note: States may not use the funds to purchase any items for consumers/clients.

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- Enhance the primary prevention infrastructure within your state and communities using the Strategic Prevention Framework planning model and implementing evidence-based practices, the six CSAP prevention strategies with an emphasis on environmental approaches.
 - Consider incorporating strategies around adverse childhood experiences to improve substance misuse outcomes among all populations, but especially young adults 18-25 and those over 26 years of age; preventing and reducing marijuana use by youth below the state's legal age of use; and mitigating the impact of increased alcohol access by youth as identified during the COVID-19 pandemic. It is important to identify and address disparities and describe how you are incorporating equitable approaches.
 - Support expansion of peer-based recovery support services (e.g. recovery community organizations, recovery community centers, recovery high schools, collegiate recovery programs, recovery residences, alternative peer group programs) to ensure a recovery orientation which expands support networks and recovery services. These programs are helping people sustain their recovery, engaging families and significant others, bridging the gap between treatment and long-term recovery, and supporting people reentering the community from incarceration.

SAMHSA requests that the following information is included when submitting the proposals:

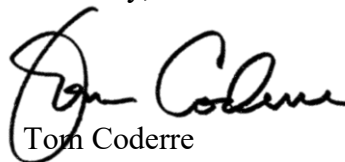
1. Identify the needs and gaps of your state's SUD services continuum, related to developing a comprehensive prevention, intervention, treatment, and recovery support services continuum.
2. Describe how your state's spending plan proposal will address the state's substance use disorder services continuum, including a budget that addresses the needs and gaps related to this continuum.
3. Describe your state's progress in addressing the rising drug overdose rate in many parts of the country, and what steps the state will be taking to improve access to SUD treatment, by improving identification of persons in need, reducing barriers to admission to treatment, and strengthening mechanisms to promote client engagement and retention in SUD treatment and recovery support services.
4. Describe your state's progress in implementing the increased and widespread use of FDA approved medications for the treatment of opioid use disorder, alcohol use disorder, and tobacco use disorder, in combination with other substance use disorder evidence-based treatments and practices.
5. Explain how your state plans to collaborate with other departments or agencies to address the SUD services continuum.
6. Describe how the state plans to use SABG ARPA funding to promote health equity among identified underserved populations, and how it plans to address health disparities in the planning, delivery, and evaluation of SUD prevention, intervention, treatment, and recovery support services.
7. Describe the state's efforts and plans to promote an increased emphasis on the development, delivery, and support of widespread SUD recovery support services, systems, and mechanisms across the state.

-
8. Describe other state priorities or activities that the state plans to fund during the performance period of September 1, 2021 through September 30, 2025 using ARPA funds.
 9. Describe your state plans for enhancing your state’s prevention infrastructure which may include incorporating work around ACEs and improving substance misuse outcomes among young adults and older adults. (Primary Prevention set-aside)
 - a. The impact of increased access to marijuana and the state’s strategies to prevent misuse by the underage population.
 - b. Strategies to reduce the COVID-19 impact of increased alcohol accessibility and misuse.
 - c. How the state is using equitable strategies to reduce disparities in the state’s prevention planning and approaches. Using the WebBGAS Revision Request for the FFY 2021 Block Grant Application, upload the document (Microsoft Word or pdf) using the tab into the State Information Section, Chief Executive Officer’s Funding Agreement – Certifications and Assurances/Letter Designating Signatory Authority [SA]. Please title this document “ARPA Funding Plan 2021 (SA).”
 10. Describe how the state will use, or considered, health IT standards if using funds for health IT infrastructure or advancement. This includes a description of standards and, as applicable, conformance to Office of the National Coordinator certification criteria in health IT products used or that will be used to support SUD clinical priorities and interoperable data exchange. States must use standards identified by the Office of the National Coordinator for Health IT in 45 C.F.R. 170 where applicable and also should consider standards identified in the Interoperability Standards Advisory (<https://www.healthit.gov/isa/>), including but not limited to those standards described in the “Allows for the Exchange of State Prescription Drug Monitoring Program (PDMP) Data” section and the “Social Determinants of Health” section.

States must upload separate proposals based on MHBG and SABG guidance into the WebBGAS system. Upon submission, SAMHSA will review the proposal to ensure it is complete and responsive. Proposals must be submitted to WebBGAS by Friday, July 2, 2021, 11:59 EST.

SAMHSA is ready and willing to assist you in addressing the needs of individuals with mental illness and substance use disorders. Please feel free to contact your SAMHSA state project officers and grants management specialists with any questions that you may have.

Sincerely,



Tom Coderre

Acting Assistant Secretary for
Mental Health and Substance Use

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Technology's Acceleration in Behavioral Health: COVID, 988, Social Media, Treatment and More

No. 9

NASMHPD

Ready to Respond:
Mental Health Beyond Crisis and COVID-19

September 2021

Technology's Acceleration in Behavioral Health: COVID, 988, Social Media, Treatment and More

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Cover Art by Malkah Pinals

Ninth in the 2021 Ready to Respond Series of Ten Technical Assistance Briefs focused on Beyond Beds, Reimagining a Sustainable and Robust Continuum of Psychiatric Care



National Association of State Mental Health Program Directors

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September 2021

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Recommended Citation:

Phillippi, S., Bumbarger, B. (2021). *Technology’s Acceleration in Behavioral Health: COVID-19, 988, Social Media, Treatment and More*. Technical Assistance Collaborative Paper No. 9. Alexandria, VA: National Association of State Mental Health Program Directors.

This work was developed under Task 2.2 of NASMHPD’s Technical Assistance Coalition contract/task order, HHSS283201200021I/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

Abstract:

Advances in technology offer options for the millions of Americans who experience mental health conditions, since most lack access to care or are not receiving the care they need. The permeating presence of technology in our lives offers a previously unimaginable window on both population and individual level data to inform models of epidemiology and etiology of mental health and mental illness, and the potential to provide behavioral health care in drastically different ways. While much of the advances have focused on access, growing attention is being given to quality. This quality includes issues of confidentiality, ease of use, reimagining therapeutic relationships, and improving mental health outcomes. This change has been accelerated by the COVID pandemic, particularly when the need arose to rely on technology vs. traditional in person treatment. This paper explores telehealth, artificial intelligence (AI) in social media, 988, apps, software and more related to behavioral health. As the evidence of effectiveness grows, behavioral health technologies have the potential to reach more clients and help engage and retain them in services in a cost-effective manner. It will also be critical to ensure that the use of technology is done with a sense of fairness and equity so that any individual, in any setting, can have access to equivalent care. Thus, it is imperative that there be intentionality surrounding the advances in the use of technology to avoid a second tier “behavioral healthcare-lite” system for marginalized populations that in fact have the highest needs but are hardest to reach.

Highlights:

- Technology can increase options for the nearly 1 in 5 Americans who experience a mental health condition, since most lack access to care, and over half are not receiving the care they need.
- Tele-mental health potentially addresses two significant problems in behavioral health: the critical shortage of behavioral health professionals and the logistical and financial challenges of providing services to rural populations.
- There are intentional efforts by software developers to encourage the public to engage technology for behavioral health, self-help.
- Social media platforms are using artificial intelligence to detect and communicate regarding mental health concerns, particularly related to suicide.
- It is critical to ensure that the use of technology is done with a sense of fairness and equity so that any individual, in any setting, can have access to equivalent care.

Recommendations for the post-COVID-19 future:

1. Much more empirical evidence is needed to determine the effectiveness of behavioral health technologies in relation to populations and specific mental health conditions. As that evidence grows it is also critical that translation of that science into practice happens in order to reach more consumers and help engage and retain them in needed services in a cost-effective manner.
2. Technology, particularly the increased capacity to capture and analyze large data sets, will allow new examinations of individual and population behavioral health and subsequently strengthen our etiologic models and the potential design of new interventions.
3. The drastic changes in the delivery of behavioral healthcare, brought on by technology, demand a re-examination of the supporting infrastructure and workforce to ensure that high quality is maintained as access increases.

As of 2021, 97% of Americans owned a cell phone, and over 85% owned a smart phone, compared to just 35% owning a smarty phone just a decade ago.¹ Furthermore, 72% of U.S. adults say they use at least one social media site (up from 43% just a decade ago).² Among 18- to 29-year-olds, approximately 84% are social media users, followed by 81% of persons between ages 30 to 49, 73% of those 50 to 64, and 45% of 65 and older individuals.³ These technologies offer options as more than 43 million Americans, nearly 1 in 5, experience a mental health condition, most lack access to care, and over half are not receiving the care they need.⁴ In addition to opportunities for general use, the ubiquitous presence of technology in our lives offers a previously unimaginable window on both population and individual level data, which can inform models of epidemiology and etiology of mental health and mental illness. As such, technology has the potential to transform behavioral health care delivery in drastically different ways.

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.

–Nemec and Chan, 2017. p341

Technology in behavioral health care is evolving at a rapid pace. Nevertheless, there are three cornerstones of effective behavioral healthcare that need to be considered regardless of the technological advancement. These cornerstones include access to care, timeliness of service delivery, and high-quality services. Although much of the technological advances have focused on access, growing attention is being given to the quality of services. This includes issues of confidentiality, ease of use, reimagining therapeutic relationships, and effects of technology used to provide services with positive mental health outcomes.

Three cornerstones of effective behavioral healthcare:

1. Access to care
2. Timeliness of service delivery
3. High-quality services

COVID-19 fueled the rapid growth of technology implementation in mental health care delivery due to the need to transition away from traditional in-person treatment given the public health measures to control coronavirus spread.⁵ Technology will undoubtedly be a part of the future of mental health care systems, but not without growing pains and issues. This paper, *Technology's Acceleration in Behavioral Health: COVID, 988, Social Media, Treatment and More*, examines recent advances in mental healthcare technology and discusses relevant issues to their implementation Topics addressed include:

- telehealth technology
- 988 tech & mobile crisis response
- artificial intelligence in social media
- mobile-mental health apps
- emerging technology

The paper concludes with a discussion of workforce development around technology, infrastructure needs, and recommendations for the field.

Telehealth Technology

One of the most apparent uses of technology in behavioral health has been the advent of remotely delivered treatment services, often referred to as telehealth. Telehealth for mental healthcare, or tele-

mental health saw a dramatic increase in utilization during the COVID-19 pandemic. Tele-mental health potentially addresses two significant problems in behavioral health: the critical shortage of behavioral health professionals and the logistical and financial challenges of providing services to rural populations.

The relationship between the recent dramatic increase in tele-mental health and the COVID-19 pandemic is complicated. Like previous natural disasters, the COVID-19 pandemic led to increased mental health stressors across the population, restricted movement, and drastic disruption to the traditional health care system, including mental and behavioral health care. Prior to the pandemic, a loose national agenda had already been underway to increase the use of tele-mental health in order to expand access to behavioral health services in rural and underserved communities, but the quarantine orders that came to most states early in the pandemic forced an urgent shift to remote behavioral health services. The pandemic revealed the critical limitations of conventional in-person behavioral health treatment, as well as the fragility of the traditional referral networks patients and practitioners have come to rely upon to connect people to needed services. Policymakers recognized this fragility and need for adaptations by offering regulatory flexibility, and providers and practitioners developed innovative strategies to quickly pivot to a variety of remote delivery models, potentially reaching new patient populations.

As a state-level intermediary supporting the improvement of behavioral health services for Medicaid-eligible children, the Center for Evidence-to-Practice at Louisiana State University both assisted and studied practitioners' transition to tele-mental health during the early months of the pandemic and quarantine order. Most practitioners, whether implementing evidence-based treatment models or otherwise, reported they were able to effectively transition to some hybrid variation of tele-mental health to continue providing services.⁶ This transition to tele-mental health was facilitated by temporary regulatory flexibility in Medicaid and HIPAA regulations, support from national model purveyors (such as Multisystemic Therapy and Functional Family Therapy), intermediaries (such as the Center for Evidence-to-Practice) and professional support networks, and practitioners' own innovation (e.g., developing hybrid models that combined video conferencing, chat and text messages).⁷ Although most providers were able to successfully shift to tele-mental health in this setting, they reported, and separate Medicaid claims data confirmed, a significant decrease in the number of referrals received and clients served in the first six months of the pandemic (a time when one would expect both referrals and clients to increase significantly). This not only challenges the tele-mental health goal of expanded access to behavioral health services, but also raises concerns about the potential of increasing disparities in already underserved populations such as those living below the poverty line, of minority races/ethnicities, or living in rural areas.

Similar to Louisiana's experience, the National Association of State Mental Health Program Directors (NASMHPD) Research Institute found that nearly 88% of state mental health systems reported their community providers experienced a significant decrease in clients since the beginning of COVID-19.⁸ Of these providers, 71% reported that decreases have been significantly, but not totally, offset by the use of tele-mental health, and 15% reported that tele-mental health has not significantly offset the loss in clients, indicating an overall net reduction in clients served in both cases.⁹ Likewise, respondents to the NRI survey reported that the added regulatory flexibility with Medicaid and HIPAA was invaluable in transitioning to tele-mental health during COVID-19. This emergency transition to tele-mental health has important implications for the financial stability of community behavioral health providers as well, with NRI reporting that 29 states have had to provide supplemental funds to community providers to keep them solvent, at a time when those providers should be investing in technology and training to effectively use it.

Another important consideration for the field's rapid shift to tele-mental health delivery of behavioral health services is the potential impact on treatment quality and effectiveness. One of the factors slowing the expansion of tele-mental health prior to the COVID-19 pandemic was the seemingly conflicting agenda to scale up evidence-based models. The fundamental argument for prioritizing evidence-based treatment models over standard behavioral health practice was the strong empirical support from randomized trials of these interventions, imparting a much stronger confidence in effectiveness and offering standardized treatment protocols (validated in the same trials) to promote better treatment adherence. Many evidence-based behavioral health treatment models have developed tele-mental health adaptations but have not rigorously tested them in clinical trials. These tele-mental health adaptations are grounded in the same behavior change theories and etiologic frameworks as the original evidence-based versions, so it is unlikely they would be totally ineffective. However, there is evidence that important characteristics of the curative process, such as the therapeutic alliance between patient and clinician, may be negatively impacted by a tele-mental health environment and thus may weaken key outcomes.^{10,11}

988 Tech & Mobile Crisis Response

In conjunction with telehealth, states are finding use of this technology with the rollout of 988 and crisis mobile services. Increasing the ease of calling for help in a crisis, requires increased need for effective response. Technology is allowing interconnectedness between call centers, as well as GPS tracking for emergency response and locations of available services.

For example, states are actively engaged in discussions of how to transfer behavioral health crisis calls from 911 (and back if needed). Ruiz (2021) reported that Austin, Texas became one of the first cities in the country to add a fourth options for 911 callers. Operators now ask if the caller needs emergency medical, police, fire, or mental health services. Those in need of mental health services are transferred to a mental health provider. This interconnectedness of services has reported that 86% of mental health calls are now being resolved without the need for police. However, if and when law enforcement is needed for public safety reasons, they remain connected for that request from mental health providers. Austin is not alone, in Phoenix, Arizona an interconnected consortium of nonprofit agencies has built a crisis line and mobile response system, that is handling about 20,000 calls per month, dispatching mental health providers, rather than police, in about 2,200 instances a month, again with the vast majority of calls resolved on the phone.¹² As the new 988 suicide hotline is implemented nationwide, it is anticipated that this will also be further integrated with these system of response.

Colorado has blended its response technologies with telehealth. According to Neylon (2020), writing on behalf of the National Association of Mental Health Program Directors, Colorado is implementing a model that uses trained bachelor's level or peer specialists, who bring tablets into the field when responding to people in crisis. These devices are used to connect the individual to a masters-level clinician via telehealth services to offer a formal triage and recommendations for the level of immediate care assessed.¹³ Similarly, in Charleston County, South Carolina EMS is equipped with telehealth technology for mobile crisis teams to triage crises virtually and make recommendations on next steps.¹⁴ This service is structured in a way that quickly places ambulance services back into rotation, reduces mobile crisis drives to longer distance locations if not warranted, and limits over utilization of transport to emergency departments for similar mental health assessment.¹⁵

Using GPS tracking for emergency location of people and available services can also improve crisis response. GPS location of the nearest mobile crisis response team helps link teams to those in need with the shortest response time options. Having caller id functioning and implementing GPS-enabled technology to more efficiently dispatch care to those in need is also listed in the best practices noted by SAMHSA.¹⁶ According to these guidelines, “GPS-enabled Mobile Crisis Dispatch Mobile crisis teams should use GPS-enabled tablets or smart phones to support quick and efficient call hub determination of the closest available teams, track response times, and ensure clinician safety (e.g., time at site, real-time communication, safe driving, etc.).”¹⁷

According to SAMHSA, best practices to operate regional crisis call centers should include utilizing real-time bed registry technology to support efficient connection to needed crisis resources.¹⁸ Bed registries, like those implemented in Georgia, show the availability of beds for crisis stabilization, with interactive exchanges between hospitals and crisis teams. According to TTI Bed Registry Project (2019), Georgia’s call-center clinicians, walk-in crisis centers, emergency departments, jail staff, and mobile crisis teams can refer individuals requiring a bed for crisis stabilization to a receiving facility. The system monitors bed occupancy as facilities enter bed availability in real time as admissions and discharges occur. System data show occupancy in crisis stabilization beds at 90% or better, denials at 10% or less, and an average length of stay of seven days or less.¹⁹

Artificial Intelligence in Social Media

Much of technology is being encountered by consumers and communities without individuals necessarily realizing the impact on population mental health, by using artificial intelligence (AI) technologies. AI is defined as intelligence demonstrated by machines as “intelligent agents” that perceive an environment (e.g., social media platforms) and takes actions to achieve a goal, take action, or problem solve.²⁰ With suicide the second leading cause of death for 15– to 29-year-olds,²¹ and US military veterans committing suicide at rates 1.5 times that of the non-veteran population,²² social media is in a unique position to intervene and attempt to connect those in distress with support.^{23,24} Facebook has been using its artificial intelligence to detect and send alerts regarding suicide concerns since 2017.²⁵ The goal was to get timely help to those posting things that might indicate suicidal ideation and/or send resources to those posting concern about friends or family members suicidality. In practice, Facebook automatically sends messages of concern and links to resources when suicidality is suspected with no human interface. Although this may be better than nothing, it also leaves all of the next steps to the receiver of the message. The effectiveness of these non-human interactions with Facebook artificial intelligence AI remains to be further explored as no data are being shared on outcomes.²⁶ One study did examine the importance of artificial intelligence interaction with some Facebook users at increased risk for suicide. Specifically, a study of Facebook users with high rates of use, described as addictive, are also known to have higher risk of suicide.²⁷

Mobile Mental Health Apps

There are also intentional efforts by software developers to promote the public to engage technology for self-help. This is evidenced by simply picking up your smartphone and typing mental health in your app store. Almost a third of the health-related apps focus specifically on mental health.²⁸ One will find a myriad of apps that use techniques borrowed from evidence based practices such as Cognitive Behavioral Therapy to address issues like depression, anxiety, post-traumatic stress disorder (PTSD),

obsessive-compulsive disorder (OCD), and more without the presence of a trained provider or physical psychotherapy room/clinic. During COVID-19 several states, like New York, promoted accessible apps to help individuals manage anxiety and social isolation.²⁹ More data will be needed over time to understand how these tools fit into the array of available supports. Nevertheless, some are quite popular. The top self-help mental health apps of 2021 are listed in Table 1.

Table 1: “Top mental health apps of 2021”³⁰

Behavioral Health Focus Area	App Examples	Basic Information
Suicide Prevention		
	MY3	Customize to user warning signs, offers coping strategies, and links to resources.
	notOK	Designed for adolescents as a means to let identified friends, family and support networks know help is needed
General Mental Health		
	What’s app	CBT and ACT methods
	MoodKit	CBT based with activities to improve mood
Addiction		
	Twenty-Four Hours a Day	meditations to focus on sobriety
	Quit That!	a recovery tool to track habits to help quit alcohol, smoking, drugs
Anxiety		
	Mindshift	changing how users think about anxiety through encouragement, assisting riding out intense emotions, etc.)
	SAM- Self-help for Anxiety Management	users build their own 24-hour anxiety toolkit from 25 different techniques
	CBT Thought Record Diary	helps identifying negative and distorted thinking patterns
Bipolar Disorder		
	IMoodJournal	personal journal and mood tracker to record mood, symptoms, sleep mediations and energy cycles
	eMoods	track depressive and psychotic symptoms, elevated mood, and irritability to indicate severity of symptoms
Depression		
	Happify	mood-training program
	MoodTools	CBT approach using videos to improve mood and behavior & log thoughts

Behavioral Health Focus Area	App Examples	Basic Information
Eating Disorder		
	Recovery Record	record meals, feelings, and complete questionnaires to track progress
	Rise Up and Recover	track meals and associated feelings, urges, coping strategies
Obsessive-Compulsive Disorder		
	nOCD	mindfulness and exposure response prevention treatment, assessments, and motivation support
	Worry Watch	identify trigger points for anxiety, trends, reflection on harmless outcomes, change of thinking patterns
	GG OCD	games and techniques to increase awareness of negative thoughts and training to push these aside for more positive outcomes
PTSD		
	PTSD Coach	self-assessment, support opportunities, positive self-talk, and anger management tools
	Breathe2Relax	stress management tool teaching diaphragmatic breathing to decrease fight or flight response
Schizophrenia		
	UCSF PRIME	connects to peers to decrease social isolation and options to track goals
	Schizophrenia HealthStorylines	tools to monitor condition, symptoms, medication, and moods
Mindfulness and Meditation		
	Headspace	teaching tools to develop skills of mindfulness and meditation targeting stress, anxiety, sleep, and focus
	Calm	guided meditations, sleep stories, breathing programs, and relaxing music for countering stress and anxiety
	Ten Percent Happier	guided meditations, videos, stories, and inspirational pieces to address anxiety, stress, parenting, sleep, etc.

As noted by Psycm, these apps are not necessarily a replacement for therapy, but they are anywhere from free to very reasonably priced as compared to the cost of traditional mental health therapy. Besides cost-efficiency, they also make help more accessible, with response times in the minutes, and portable.³¹ Of course, mental health care apps do not promote equity in access for those that may not be able to afford a smartphone, have access to affordable or free broadband networks, or lack skills to use smartphone technology.

Behavioral health experts in the field are also paying close attention to the benefits and risks of these rapidly emerging apps. According to the National Institute of Mental Health (NIMH), the pros of mental health apps include convenience, anonymity, introduction to care (i.e., first step for those that might avoid care), lower cost, service to a wider population of people, interest (i.e., appeal), round-the-clock access, consistency, support (including for those in therapy), and data collection (e.g. location, movement use, etc.).³² These advances also come with concern. Currently these include questions about effectiveness, appropriate target populations for their use, as well as appropriate target conditions that they aim to ameliorate, privacy (from IP addresses to who stores what data), industry-wide standards, regulation, and overselling (i.e., promising more than the app delivers).³³ Regarding standards and regulation, NIMH created the National Advisory Mental Health Council Workgroup on Opportunities and Challenges of Developing Information Technologies on Behavioral and Social Science Research in order to offer guidance and monitor rapidly changing use of technologies. In 2017, the NIMH advisory council noted that digital health is no longer limited to the technologically savvy.³⁴ With more than 2.2 billion people in the world with a smartphone, including almost two-thirds of minority and low-income populations, these mental health technologies are more accessible than ever.³⁵ Researches have also noted this, as internet-based and mobile device-based data collection for studies has increased with tools for sample population recruitment, retention, and information collection.³⁶

The BRIGHTEN study, a randomized controlled study examining the use of technology to deliver mental health treatment serves as an opening to learn about utility and outcomes of these technological tools as augmentations to traditional therapies.^{37,38} According to the research findings currently released, the three apps tested to treat depression had a significant impact on mood and level of functioning over time, though one of the limitations turned out to be the challenge in keeping participants engaged in the research itself. The research team is still analyzing data to determine how well the apps treated depression and if one app was better than the others.^{39,40}

Still, the largely untested and unregulated mobile behavioral health application market leaves it vulnerable to unscrupulous, unethical, or simply well-meaning but untrained app developers, making it difficult for consumers or even professionals to navigate to mobile apps that are safe, secure, and effective. Although some have argued the breakneck pace of the evolving technology makes it impractical to hold these apps to the same rigorous standards of randomized trials, others have suggested that basing apps on evidence-based treatment models might be a rational compromise.^{41,42}

Several entities offer emerging guidance pertaining to these technologies. One advisory board for mental health information technology points out that the many systems of healthcare for serving those struggling with mental health conditions (mental care, physical care, hospitals, etc.) need to treat patients holistically, communicate, and coordinate care. The increase reliance on pay for performance also suggests considerations for integrating technologies. A few highlights are that technology still needs to prove itself; patient engagement is critical to success; and, product quality controls are needed.⁴³ To this latter point, the group suggest practitioners examine if the product has been tested for use with an intended audience (including RCTs), and if behavioral health professionals (e.g., psychologists, social workers, or other licensed mental health providers) contributed to the development of the technology.⁴⁴

SAMHSA's Using Technology-Based Therapeutic Tools in Behavioral Health Services is an available resource for treatment providers at <https://store.samhsa.gov/sites/default/files/d7/priv/sma15-4924.pdf>

Emerging Technology

In addition to the commonly used app and social media platforms for the general public, behavioral health providers are increasingly using technology approaches to support their work with consumers. Therapists are capitalizing on these tools to improve care for their clients. They are recommending app use for homework and self-care (see the apps listed above as an example), using them to provide direct care, and supplementing conventional care using ecological momentary assessment to collect frequent real-time passive self-reports and to provide intensive outpatient monitoring.^{45,46}

One example of software to assist therapist and clients is Talkspace Online Therapy. 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.⁴⁷ With benefits listed such as 24/7 access, no commute/transportation and scheduling hassles, seamlessly switching therapists for continuity of care, they are certainly addressing several of the barriers to treatment. For too long, it has been recognized that the top barriers to behavioral health treatment are cost, awareness, stigma, and accessing a provider.⁴⁸ However, there are currently no data available to show the effectiveness of this online therapy approach. Funding to support research on the effectiveness of these types of strategies to help populations with diverse needs, could help determine the utility of this approach.

As therapists and therapies become more tech savvy, approaches are emerging to enhance the therapy environment itself. Once such approach is the use of avatars (digital self-representations) to facilitate online communication between therapists, clients, and peers. According to Rhem et al. (2016), there are four key ways that avatars are being used in therapy. These include:

- online peer support communities;
- using avatars to communicate and interact in a therapeutic environment;
- to participate in skills building games; and,
- to communicate with an autonomous virtual therapist.

The research suggest that the use of avatars helps clients engage, form therapeutic alliances, seek treatment due to anonymity, express and explore their identity, and reduces communication barriers while the therapists can control and manipulate treatment stimuli.⁴⁹ However, as noted like all these new technologies further research on feasibility, effectiveness, and ethical use is needed.

More research in this area may be coming. Between 2009 and 2015, NIMH awarded over 400 grants and almost \$4.5 million dollars to research technology-enhanced interventions designed to prevent or treat mental health disorders.⁵⁰ These interventions are trending away from computer use and more to mobile devices and include interactive formats and game-like approaches. They also include both active (engaged treatment) and passive (data collection, artificial intelligence, machine learning and automated responses) for assessment and monitoring.

Technology and Workforce Development

For decades, the United States child and adolescent mental health workforce has suffered from a severe shortage and poor children and rural communities have consistently borne the brunt of that unmet need.^{51,52} The COVID-19 pandemic amplified both the workforce shortage and service disparities by

simultaneously reducing the workforce and further isolating children in need. Technology has the potential to address the workforce shortage in three ways:

- technology can potentially be used to reduce the overall prevalence of behavioral health problems by detecting relatively minor problems when they are easier to treat and may be treated through self-help strategies such as the apps described previously.
- technology can potentially be used to increase access to effective treatment models through TMH. As described previously, the use of technology and the dramatic increase of TMH has been a critical strategy to increase access.
- technology can be used to increase the reach, cost-effectiveness and quality of training and professional development for the behavioral health workforce.

Simultaneously however, such dramatic shifts in practice are fundamentally redefining the delivery of children's behavioral health care, and thus will require a significant re-tooling of the workforce. Dissemination and implementation science makes clear that the high-quality, widespread adoption of any significant new technology in a given field requires the use of intentional and adequately funded adoption strategies, including developing and maintaining the required competencies for providers to use the new technologies and the protections of the rights of people who will access the technology-supported services.⁵³ With subsequent future innovations, it will be important to remember that the technology itself is not self-actualizing, and to adequately plan for, fund, and take the time to develop the workforce capacity necessary to make optimal use of the technology.

Several exemplars have emerged in recent years to demonstrate the innovative technology strategies being employed to build and strengthen the behavioral health workforce. These include:

- The Behavioral Health Education Center of Nebraska's Virtual Mentor Network has created a state pipeline program for future behavioral health professionals using online virtual sessions for rural college and high school students.⁵⁴
- The University of Hawaii has partnered with the Mayo Clinic in a model program to develop an expert children's mental health workforce to serve geographically isolated and culturally diverse communities using interactive video teleconferencing (IVTC) and tele-mental health, strengthening collaboration with local primary and behavioral health providers.⁵⁵
- In Project ECHO (Extension for Community Healthcare Outcomes) a hub-and-spoke virtual training and coaching model originally developed at the University of New Mexico for Hepatitis C care, the Addiction Training and Technical Assistance Center (ATTC) utilized the model to facilitate an IVTC knowledge-sharing network conducting virtual mentoring with locally based substance use treatment supervisors, to enhance workforce capacity to provide clinical supervision.⁵⁶ The ATTC chose clinical supervision to test this virtual training and coaching model based on its centrality as a workforce development amplifier.
- Putney et al. (2019) describe an online interactive technology used in advanced level Master of Social Work programs to offer virtual client simulations (PeopleSim) as a tool to train screening and brief intervention and motivational interviewing. The virtual and asynchronous nature of the "patient" offers tremendous cost, convenience, and consistency over traditional live patient training, and students demonstrated significant pre- to post gains in screening and brief intervention skills, motivational interviewing skills, and change planning skills. Though no comparison group was included in the evaluation, this study demonstrates the potential efficacy of this innovative workforce development strategy.⁵⁷

These are just a sampling of some of the innovative technology approaches being used to increase the size and the skills of the behavioral health workforce, offering an exciting glimpse of the future of training and professional development.

Infrastructure Needs

To understand the magnitude of the infrastructure and capacity challenge that comes with the adoption of these multiple technological innovations, it is instructive to look at the adoption of electronic health records (EHR) which began in earnest with the passage of the Health Information Technology for Economic and Clinical Health Act of 2009 (more information available at <https://www.hipaajournal.com/what-is-the-hitech-act/>) and the associated government stimulus. Although this combination of enabling legislation and financial incentives created rapid expansion of electronic health records over the past decade, the development of the technology and the necessary workforce capacity has been a story of uneven progress of fits and starts, and psychiatry and related fields have had the lowest adoption rate of all subspecialties.⁵⁸ Although well-designed EHR systems can increase efficiency and streamline services, it is equally common to see poorly designed or implemented systems with poor user interfaces that increase inefficiencies and errors, risk security breaches, and compromise the quality of health care and patient safety.

For the behavioral health and addiction fields, a new national infrastructure is in place and poised to make good use of technology platforms to provide training and professional development. To address the national opioid epidemic in the years immediately prior to the COVID-19 pandemic, Congress appropriated over \$3 billion to the Substance Abuse and Mental Health Services Administration (SAMHSA) to establish a national infrastructure of Technology Transfer Centers (TTCs), including the Addiction TTCs (ATTC Network), Prevention TTCs (PTTC Network), and Mental Health TTCs (MHTTC Network). These TTCs are tasked with building the capacity of the local behavioral health workforce to provide evidence-based interventions.⁵⁹ In response to stay-at-home orders in early Spring 2020, the entire TTC infrastructure rapidly shifted its full continuum of training and technical assistance to a multi-tiered virtual platform to offer uninterrupted remote service delivery. The TTCs have reported increased convenience and decreased costs in connecting local service providers with trainers and technical assistance providers, but have also noted inequitable access, especially for rural practitioners and communities, based on bandwidth limitations and some discomfort with technology. Overall, the TTC network represents a great potential national infrastructure for continuing to use technology to strengthen and support the mental health workforce.

Questions Remain

With the advances, questions and concerns have arisen that remain to be addressed. For example, it is not clear how service providers will need to respond when individuals just stop coming to virtual spaces. Another question is 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 member's IP address to determine exact location to send first responders, but it is often more difficult to determine the client's level of risk in messages. Thus, it is unclear whether crisis response will be overutilized or underutilized. The American Psychological Association points out several other critical issues practitioners must attend to such as HIPAA compliance and patient privacy protections of technology based communications, state licensing laws for practitioners treating patients when their location may

be beyond their legal or ethical treatment allowance (e.g., talking to someone in a state where the provider is not licensed), as well as the ethics and practice parameters with the use of the many apps and platforms that allow users to remain anonymous.^{60,61}

Another area of exploration needed regarding the increased infusion of technology is the potential disparities in care between large health care systems versus small providers and individual mental health practitioners. The significant investment in the technology, associated training and maintenance, and necessary cybersecurity may be financially out of reach for small organizations and sole proprietors. Many of these issues were not dealt with at the height of the pandemic when the major driver was to decrease any disruption in services, but as technology is integrated more into the work of behavioral health, these questions will need answers.

Conclusion

As the evidence of effectiveness grows, behavioral health technologies have the potential to reach more clients and help engage and retain them in services in a cost-effective manner.⁶² Although technology can drastically increase access to behavioral health care for otherwise marginalized populations, there are many nuanced aspects of it that require further study, and thus it cannot be seen as a panacea. Similarly, although some would argue that the shift to more technological approaches to behavioral health have the unintended potential to disconnect behavioral health professionals from their clients on a personal, human level, there has been a great deal of experience with technology as a result of COVID-19 that has been positive. Consistent throughout the literature is the theme that technology is not intended to replace in-person client contact. The current focus is almost always on how technology, when incorporated into treatment and prevention efforts, can supplement existing methods and provide services to clients who might not otherwise receive treatment. This may change as artificial intelligence and machine learning technology improves, but for now, it appears that technology will be a supplement to other forms of psychiatric care. As the behavioral health field evolves, it will be critical to ensure that the use of technology is done with a sense of fairness and equity so that any individual, in any setting, can have access to equivalent care. Thus, it is imperative that there be intentionality surrounding the advances in the use of technology to avoid a second tier “behavioral healthcare-lite” system for marginalized populations that in fact have the highest needs but are hardest to reach. Aware of the growth and potential, but also recognizing all the unknowns, the American Psychological Association cautions to tread carefully. They urge practitioners to consider the fit of technology with different clients and the seriousness of their level of risk and need.⁶³

Tele-mental health, mobile care apps, artificial intelligence, and infrastructure technology have undeniably revolutionized every aspect of behavioral health and will continue to do so as further innovations are developed. As described throughout this article, this suite of technologies has the potential to:

- Dramatically increase access to quality behavioral health care,
- Connect consumers to behavioral health care where and when it is most convenient, potentially reducing barriers of geography and stigma,
- Promote wide scale and unobtrusive assessment and screening to promote early identification of mental illness and substance use issues,
- Empower individuals to self-manage their own emotional wellness, potentially reducing the overall prevalence of serious mental, emotional and behavioral problems,

- Increase the pace, scale, efficiency and accuracy of behavioral health research in order to improve the effectiveness of behavioral health care and reduce morbidity and mortality, and
- Improve the coordination of care.

The United States is in an uncomfortable era in behavioral health care, with one foot in the old way and one foot in the new. The mental health system is seeing the promise of technology but have not yet worked through all the important challenges of the transition. But the promise of technology is undeniable. For technology to demonstrably, collectively impact population-level behavioral health, it will require a coordinated and optimized effort that adequately addresses all three key variables: need, access and quality. Individually, there is ample proof of concept that technology can address each individually. Through low-cost self-help apps and artificial intelligence that passively identifies the earliest signs of dysfunction or dysregulation, the overall prevalence of behavioral health problems could potentially be reduced. Through tele-mental health adaptations of evidence-based treatment models and policy initiatives to ensure adequate broadband access to every home, there is the also the potential to ensure that all who need behavioral health services will have access to them. Technologically innovative training, workforce development, infrastructure advances and quality assurance strategies will help to ensure that behavioral health services are delivered by highly trained professionals ensuring adherence to strict treatment protocols in a coordinated system of care.

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Using Data to Manage State and Local-level Mental Health Crisis Services

No. 10

NASMHPD

Ready to Respond:
Mental Health Beyond Crisis and COVID-19

September 2021

Using Data to Manage State and Local-Level Mental Health Crisis Services

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Cover Art by Malkah Pinals

Tenth in the 2021 Ready to Respond Series of Ten Technical Assistance Briefs focused on Beyond Beds, Reimagining a Sustainable and Robust Continuum of Psychiatric Care



National Association of State Mental Health Program Directors

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September 2021

Acknowledgements:

The author would like to thank the following individuals for sharing invaluable insight and providing guidance about this important topic: Megan Lee, M.A., L.P.C. and Tim Gruzeski, M.A., with the Colorado Office of Behavioral Health’s Crisis Services; Devin Teicher and Jenn Conrad, M.S.W., L.C.S.W, C.C.M., with Signal Behavioral Health in Colorado; Claire Wang and Glenn Owens from Delaware Division of Substance Abuse and Mental Health; Debbie Atkins, Anna Bouque, and Terri Timberlake, with the Georgia Department of Behavioral Health and Developmental Disabilities, Dawn Peel and Jennifer Dunn, with the Georgia’s Southwest and East-Central Regional Field Offices; Josh Cantwell, with Grand Lake Mental Health Center in Oklahoma; Nicole Cunha and LeAnne Huff, with Utah’s Division of Substance Abuse and Mental Health Treatment Services; David Reed, with Washington State’s Health Care Authority; Joe Avalos, Chris Foster, and Valerie House, with Olympic Health and Recovery Services (Thurston and Mason Counties Behavioral Health Services); Ted Lutterman, and Kristin Neylon, M.A., with the NASMHPD Research Institute, and Debra A. Pinals, MD Chair, Medical Directors Division National Association of State Mental Health Program Directors Medical Director, Behavioral Health and Forensic Programs Michigan Department of Health and Human Services Clinical Professor of Psychiatry Director, Program in Psychiatry, Law and Ethics, University of Michigan.

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Recommended Citation:

Shaw R. (2021). Using Data to Manage State and Local-Level Mental Health Crisis Services. Technical Assistance Collaborative Paper No. 10. Alexandria, VA: National Association of State Mental Health Program Directors.

This work was developed under Task 2.2 of NASMHPD’s Technical Assistance Coalition contract/task order, HHSS283201200021I/HHS28342003T and funded by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services through the National Association of State Mental Health Program Directors.

Abstract:

Managing crisis services will require the collection and use of data to make decisions about how, when, and where crisis services are provided. Also, registries of available crisis services and other services in the psychiatric care continuum will help inform policymakers about access to behavioral health services and any barriers to such access. Operating crisis services will include the provision of services based more on past activities and determining specific strategies for implementation of activities. Managing crisis services is an iterative process that requires the constant collection of data or knowledge that can be used to assess all aspects of a provider's or a state's activities to continually adjust to achieve better services. Great efforts are expended to collect data that document the activities of providers, often also with the goal of demonstrating that funding has been well spent. States and their providers do not always operate in an environment where they have all the data they could use, and often the data they collect are not fully accurate or timely. Nevertheless, even suboptimal data are valuable and can provide insight albeit broad rather than minute. Management decisions can still be made, even with data limitations, and the direction taken can later shift if subsequent data indicate that a wrong turn has been taken. States and providers will do well to continually examine data and operational practices for ongoing quality improvement for the most effective crisis services possible.

Highlights:

- States and local providers interviewed are using data to manage the provision of crisis services.
- There are always more and better data that can be collected, however the lack of ideal data should be a reminder for caution but should not completely inhibit decision making. Using data to manage crisis services is an approach to solving problems and addressing needs

Recommendations for the post-COVID-19 future:

1. Data should be collected and used to understand the ways in which the COVID-19 pandemic has altered society, including where people live, how they are accustomed and comfortable interacting with the world, and their jobs and how that impacts crisis service utilization.
2. Crisis services should be managed in a way that adeptly meets needs both within and subsequent to the pandemic.
3. Technology can be used to enhance registries and locator tools to inform data collection

The Substance Abuse and Mental Health Services Administration's (SAMHSA's) *Practice Guidelines: Core Elements for Responding to Mental Health Crises* suggests that crisis service systems include data-driven "quality-control and performance-improvement mechanisms that operate within an organization," that demonstrate what populations experience mental health crises. Data should be used for "identifying gaps, developing remedies, and monitoring the impact of these remedies." *. In the next few years, states will be implementing 988 suicide call lines. Because much of the work is still in the planning phases, it is not yet known how this will be integrated into existing crisis systems.

This current paper, *Using Data to Manage State and Local Level Mental Health Services*, explores the extent to which crisis services in states and local mental health agencies collect and use data to inform their crisis service systems. Systems can either be operated or managed. The distinctions between these types of services are as follows and further delineated below:

Operated systems: The provision of services is based more on past activities and practices and less on data.

Managed systems: Data are collected and used to make decisions about how, when, and where crisis services are provided.

Data are often collected with one specific purpose being a way to document activities at the local level and to inform leadership at the state level and at the state level to the executive and legislative branches of government. State governments have an interest in documenting that expenditures are spent according to legislation, executive priorities, effectively, and efficiently. However, this use of data lends itself more to oversight than management.

This paper will first discuss management models to understand how states could be managing their crisis service systems from the perspective of data systems. Next, it will look at the data collected by existing and proposed service registries and discuss how those data collection elements relate to management goals the states may have. Service registries are tools states use to connect individuals to services. This paper will provide an overview the types of service registries that currently exist and then review how some states are using data to manage their crisis service systems. The ambition, depth, functionality, and use of registries vary by state, so state level examples of the use of data to manage crisis services will be presented.¹ Crisis services are often managed at the local level, so this paper will also describe at how local crisis service providers in several states are using data to manage their systems.

*Where specific state and local examples are described, program leaders within those regions whose services are included in this paper had the opportunity to review and provide edits to the description of their activities and the paper as a whole.

Management of Systems and the Relationship to Data

Management is the process of dealing with or controlling things or people. Harold Koontz, an influential management theorist, classified management models into six schools in 1961:

- **Management Process** - Management is a process of getting things done through people organized into groups.
- **Empirical** - Good management is based upon the experience of what did and did not work.
- **Human Behavior** – Good management is based on good relationships.
- **Social System** - Good management is based on establishing a cooperative environment.
- **Decision Theory** – Good management is based upon using a rational approach to making decisions.
- **Mathematical** – Good management is a logical process that is based on quantifiable variables.¹

Each of these types of management depends on turning information into decisions and actions. A goal must be decided upon and relevant data should be collected that allows managers to determine success in attaining their goals. In this paper, highlights of data collection across the crisis service behavioral health continuum to inform these various aspects of management will be reviewed.

Service Registries

Crisis Service Registries are tools that provide information about where there are open services for people in crisis who are determined to need a particular type of service, whether in-patient or in the community. These registries, however, require operations and management to ensure their effectiveness.

A well regulated Service Registry, being necessary for the optimization of the use of mental health crisis service capacity, especially inpatient capacity, and the treatment of individuals with mental illness in the least restrictive setting, is an evolving practice that is being supported as a promising practice for ensuring timely access to a complete continuum of care, in line with recommendations noted in *Beyond Beds (The Vital Role of a Full Continuum of Psychiatric Care)*.² A service registry, however narrow or broad its focus, is a tool whose success is dependent on its usefulness. Usefulness can be defined in many ways, such as operating without glitches and downtime, providing timely information, and reducing the wait time for access to services.

In 2020, 24 states had operating or were building behavioral health service registries. There were also regional service registries. Arizona had at least two systems, one for the northern part of the state, based in Phoenix, that was very sophisticated and successful, and one in the southern part of the state, based in Tucson, that was paper-based, and has also been successful in guiding access issues.

The existing service registries have various degrees of success with success defined as being a useful tool that allows individuals in need of behavioral health services to be placed in an appropriate care setting with minimal wait times. Registries require front-end staff entering information about service availability in their own system, as well as end-users seeking information to access services in real time. Both user experiences are critical important determinant of a registry's usefulness. It is important to note that

registries are most often used by case managers, clinicians, emergency departments, and first responders trying to place an individual in need with an appropriate service. If a user can accurately see that the services being sought are not available, then the system is successful. If the service availability information is more often wrong or not current than current and accurate, the system is not successful.

Many registries do not have real-time information. Real-time information is ideal because system users can rely upon the information in the system to be accurate at the time of their placement search. Real-time information is not absolutely necessary for a system to be successful. If a system's information is not updated in real-time but the information in the system is current enough to be relied upon by users, then the system can be successful. Even when a system has real-time information, if vacancies are scarce the system will be unsuccessful because the lack of available services will overwhelm the end-user's experience and they will eventually not rely on the system to identify proper placements of individuals being served. Thus, registry information requires balance between sufficiency of information as well as availability and accessibility of services in the first place.

Based upon site visits to states and interviews with states about their service registries, Dr. David Morrissette created a typology for these systems (Figure 1):³

Figure 1. Typology of Registry Systems

- **Search Engines:** "Users visit the website to view information on crisis bed facilities, their locations, services, availability, and contact information."
- **Referral Systems:** "In addition to providing regularly updated information on bed availability, the websites support authorized users to submit HIPAA-compliant electronic referrals to secure a bed using preset forms and protocols."
- **Referrals Networks:** "The bed registry site provides regularly updated information on bed availability supports users to submit HIPAA-compliant electronic referrals to secure a bed and supports referrals for behavioral health crisis and outpatient services to and from service providers who are members of the referral network."

Search engines are the least sophisticated of the system types. They intend only to make it easier for a bed to be found and a patient to be placed in care. Users of search engines have to contact facilities showing a vacancy to fill that vacancy with a patient. In most cases, currently used search engines are generally focused on psychiatric inpatient and/or crisis beds. Accessing the rest of the continuum of services is not addressed. For example, one would have to look elsewhere to schedule an appointment for an outpatient service. Referral systems are more sophisticated versions of search engines. Referral systems not only identify vacancies but allow users to send documents necessary to initiate placements to fill vacancies. Referral Networks are the most sophisticated and comprehensive version. They not only allow identify vacancies but allow users to schedule outpatient services.

Morrissette's typology is very useful in understanding the intent of the various registry systems. Getting facilities to participate by keeping their vacancy information current is the biggest barrier to success. If

the information is sufficiently accurate and the system is easy enough to operate that users come to it first when trying to identify available services for individuals, then the system will be more successful.

State Level Crisis Service Registry Data Collection

Crisis Service Registry Data Collection

Forty-three states with existing, developing, or planned crisis service registries were asked by NRI to report what data they expected their service registries to collect. Data collected by service registries can be used to document activities and to manage systems. The extent to which a state collects accurate and timely data determines its ability to use data to make management decisions. Based on the types of data reported collected by the 23 states with existing and developing registries at the end of 2020, and reported to be collected by the 20 states developing new service registries states have some or all of the following goals:

- Making services easier to access;
- Making services more available;
- Improving outcomes for people accessing services; and
- Improving the operation of the registry and service provision system.

As states are developing service registries, NRI gathered information on their effectiveness is measured. Several metrics were identified including service accessibility, service availability; improved outcomes for individuals served, and improved operations of the registry itself. Below are results of the information gathered from the forty-three states with existing or planned registries in terms of the percentage of states using particular metrics. Among the forty-three states with existing, developing, or planned registries, the following responses were provided (percentages are based on 43 states reporting):

Service accessibility will be measured by:

- Referral wait times (the time a caller waits to be referred to any type of treatment) (35%)
- Connection to treatment (19%)
- Denials of service (13%)
- Discharge wait time (the time a patient waits to be discharged from care) (2%)

Service availability will be measured by:

- The volume of service usage (47%)
- The geography of need (7%)

Improving outcomes for people in need of access to services will be measured by:

- Diversion from either hospitals or criminal justice (33%)
- Better treatment outcomes (14%)
- Contact with law enforcement (2%)

Improving the operation of the registry and the service provision system will be measured by:

- Provider compliance with service vacancy updates (14%)
- Training on the registry system or training of providers on the provision of services (14%)
- User satisfaction and the public perception of the system (7%)
- The performance of the registry system as a web tool (2%)

Mental Health Block Grant Reporting on Crisis Services

In 2020, Congress added a new 5% set-aside to the Mental Health Block Grant to assist states in establishing a comprehensive behavioral health services continuum (and Congress appropriated an additional \$42.25 million to the MHBG to fund this set-aside). SAMHSA's guidance to states accompanying the new funds, emphasized the CrisisNow model of a comprehensive crisis continuum described in the 2020 National Guidelines report released by SAMHSA and the National Association of State Mental Health Program Directors (NASMHPD).⁴

In 2021, states as part of their submission to SAMHSA about the use of the new Crisis set-aside were asked to report what elements of a crisis service system they were planning on implementing broken out by prevention and early intervention, intervention, stabilization, and post-crisis interventions and supports.

Thirty-eight states responded to a SAMHSA request to report on the implementation of a crisis service system. Of these states, 55% had reached program sustainability for providing someone to talk to, while 45% were in the process of implementing this service. Of these states, 26% had reached program sustainability for providing someone to respond to a crisis, while 71% were in the process of implementing this service. Of these states, 21% had reached program sustainability for providing someone in crisis a place to go for treatment, while 74% were in the process of implementing this service.⁵

States were asked to report which of the listed crisis prevention and early intervention, crisis intervention and stabilization, and post-crisis intervention and support programs they were or would including as part of their crisis service system.

Elements within Mental Health Crisis Service Systems

In the NRI's 2020 State Profiles data collection, states were asked to report on the types of crisis intervention services provided by the SMHA and the number of persons receiving these services during the fiscal year 2019. This information was augmented by data collected by NASMHPD in 2021 on crisis services provided by the states. The number of persons receiving a service within a year is not a measure with any depth. It is not clear from the data how much of the states are covered by the particular crisis services asked about. In many states, crisis services are organized locally and the state may not have a great role in their provision. What is clear is that only a small number of states with particular crisis services had easy or ready access to this service data. It is difficult to make evidence-based decisions without evidence. Management without information is difficult.

Crisis Prevention and Early Intervention

Suicide prevention was reported to be an element in the crisis service systems, planned or operational, in 90% of states. With the implementation of 988 hotlines, this is likely to change to all states. Safety Planning, a tool that results in a list of warning signs, coping strategies, and resources a person in crisis can use when experiencing future crises, is a system element in 80% of states.

Data reported by states via NRI's State Profiles for 2020 and data collected by NASMHPD in 2021 show that at least 78% percent of states currently have 24-hour crisis hotlines, with one state not reporting. NRI Profiles data show that the rate of use of crisis lines ranged from 82 to 2,684 per 100,000 of the population with an average of 789.

As planning continues with the build out of a 988 response, "988 systems" will need to connect suicidal people in crisis with appropriate services. States with successful referral systems will be well placed to provide 988 system operators with information that will allow them to connect callers with appropriate services at all levels of intensity. Not all callers will require mobile crisis intervention, yet a search engine that only reports psychiatric bed vacancies will be inadequate for the needs of a 988 system.

Crisis Intervention/Stabilization

Crisis Intervention Team (CIT)/Law Enforcement was reported to be an element in the crisis service systems, planned or operational, in 94% of states via NRI's State Profiles for 2020. CIT provides law enforcement with training that allows officers to more effectively interact with individuals experiencing a behavioral health crisis and thereby reduces stigma and helps divert people from jails to treatment.⁶

Mobile Crisis Outreach, which is community-based mobile interventions for people experiencing a mental health crisis,⁷ was reported to be in an element in 92% of states. Data reported by states via NRI's State Profiles for 2020 and data collected by NASMHPD in 2021 show that at least 73% percent of states currently have mobile crisis programs with six states unknown. Profiles data show that the rate of use in FY 2019 ranged from 9 to 1,317 per 100,000 of the population with an average of 394.

Crisis Residential/Respite services, always available, no-wrong-door facilities that access and treat people experiencing a mental health crisis,⁸ were reported to be an element in 88% of states. Profiles data and data collected by NASMHPD in 2021 show that at least 57% percent of states currently have less than 24-hour crisis stabilization units, with five state unknown, and at least 69% have more than 24-hour crisis residential units, with seven states unknown. An expansion of crisis stabilization and crisis residential programs should occur in the next couple of years. Profiles data show that the use of less than 24-hour units ranged from 1 to 1,070 per 100,000 of the population with an average of 270. Profiles data show that the use of more than 24-hour units ranged from 2 to 197 per 100,000 of the population with an average of 67.

Hospital Emergency Departments and Urgent Care were reported via NRI's State Profiles for 2020 to be an element in 86% of states. In areas following the Crisis Now model of mobile crisis teams transporting people to crisis stabilization facilities, thereby diverting away from hospital emergency departments, there would be a limited role for hospitals in addressing mental health crises.⁹

The Living Room Model (Assessment/Triage), 24-hour community crisis centers that offer people in crisis a calm and welcoming space where they receive treatment, support, rest, relaxation, and referrals to other services,¹⁰ was an element in 47% of states.

Of the states responding to the NRI survey, 27%, reported including Open Dialogue as an element in their service array. Open Dialogue is a practice developed in Finland that takes a social perspective to helping people with mental illness by including family members, friends, and co-workers in the treatment and wellness discussions.¹¹

Post Crisis Intervention/Support

Connection to care coordination, follow-up clinical care, follow-up outreach, and follow-up support were reported to be elements in the crisis service systems planned or operational in 86% of states. Care coordination refers to the coordination of care across behavioral health and general healthcare.¹²

Peer Support/Peer Bridgers are reported to be elements in 84% of states. Peer Support is the process of giving and receiving support, knowledge, assistance, and skills between people with unique lived experience with mental health conditions.¹³

Peer Bridgers are peer support specialists who assist individuals hospitalized for a psychiatric illness return to their community.¹⁴ Recovery community coaches/peer recovery coaches will elements in 69% of states.

Family-to-Family Engagement and Follow-up crisis engagement with families and the community are elements in 67% of states. Recovery-oriented community organizations are elements in 59% of states.

Using 911 Call Information for Service Prediction

Implementing 988 suicide hotlines means that states will have the opportunity, if 988 systems collect and share data, to use data to manage their crisis service systems in ways that were previously unavailable. A lot depends on how the 988 hotlines are implemented and how data elements are conceived and implemented.

For at least a decade, researchers have been using 911 call data to attempt to predict hotspots using spatial analysis to better inform policymakers.^{15,16,17} Researchers have also used 911 data to attempt to predict frequent users of emergency medical services.¹⁸ Successful data analysis is based upon accurate data. 911 call centers are typically organized locally and often have used different technologies and methodologies, which hampers the collection and analysis of 911 call data.

Beginning in 2003, the United States Department of Transportation, National Highway Traffic Safety Administration (NHTSA) has worked to define and help states implement Next Generation 911 (NG911) services that allow for the interoperability of data and call center hardware and software.¹⁹ As of 2019, 33 states have adopted a statewide NG911 plan that includes data uniformity and automated data handling.²⁰ The National Emergency Number Association (NENA) has standards related to answering and routing calls that include the number of answered calls, attempted calls, disconnected calls, diverted calls, abandoned calls, misrouted calls, call duration, and call hold time.²¹

Call centers for 911 are not necessarily service providers, rather they are trained to respond to a variety of emergencies and route the calls to the appropriate first responders,²² whereas hotline call center staff should be clinicians who are an integral part of the clinical response to a call.²³

The National Suicide Prevention Lifeline, collects information on hours of operation, speed of answer, contact handling time, on-hold time, cost per call, service level, etc.²⁴ These metrics are related to the availability and accessibility of hotline services rather than the location of the person in crisis, type of crisis, demographic information on the callers, percent seen by a mobile crisis team, percent forwarded to crisis respite or residential facilities.

A comparison of 911 call centers and suicide hotline data analytics to those of a commercial business such as Domino's Pizza may be instructive. Domino's considers itself to be a technology company that delivers pizza. Domino's tracks customer data across its franchises to determine buying patterns, including location.²⁵ Domino's has a financial incentive to optimize its resources in pursuit of increased sales. Ideally, a behavioral health crisis service system would reduce the need for its services by reducing the incidence of crises among the population it serves. They are similar in that location, type of service/pizza sold, use of materials, use of staffing, frequency of use, customer satisfaction, etc. are metrics that should be tracked and analyzed to optimize performance and efficiency. These data can answer questions such as where to place service locations, appropriate staffing levels based on historic usage data, and types of services to be provided.

Use of Data to Manage State and Regional Crisis Service Systems

Interviews were conducted with six state mental health authorities (SMHAs) and four regional providers of mental health crisis services. The states were selected based upon information that was gathered about them through previous interviews conducted with them for previous papers on crisis services and service registries. The regional crisis service systems were selected based on suggestions made by the states interviewed and, in the case of Grand Lake in Oklahoma, based upon an interview about the coordination and cooperation established between the mental health system and law enforcement.

These examples are presented in alphabetical order, by state, and not hierarchically. States differ in how they organize the provision of public mental health services, they have unique geographies, political histories, funding structures, and goals beyond optimizing the provision of services to people in need. Nonetheless, the following case studies are illustrative how crisis services data and registries are coming together as a crisis continuum of services is realized in particular regions.

Colorado Office of Behavioral Health

Colorado's crisis service continuum is split between Rocky Mountain Crisis Partners, which is the crisis hotline and text provider, and four Administrative Service Organizations (ASOs) that are responsible for seven regions. Colorado Office of Behavioral Health (OBH) directly manages the provision of crisis services at the state level, including the statewide crisis hotline, which has been contracted out to Rocky Mountain Crisis Partners. The OBH also manages the ASO contracts. The ASOs manage the provision of services and the contracts with the service providers in the seven regions. Colorado Crisis Services began

operating in 2014. Previously, and currently, the state's Community Mental Health Centers (CMHCs) provide emergency services. The services provided by the CMHCs significantly overlap the services provided through Colorado Crisis Services. The CMHCs are not all the same, often because of regional differences in funding and staffing. Colorado has one large urban and suburban area stretching from Fort Collins in the north, through Denver and its suburbs, and south to Colorado Springs. Every part of the system is expected to work seamlessly with every other part. Services are intended to be boundary-less in the sense that the closest, available mobile crisis team is supposed to take a call, even if the service location is outside of their region.

The state uses a broad definition of a mental health crisis, one defined by the caller. However, there is a narrower crisis definition used by the providers (a non-life-threatening situation in which a person experiences an intensive behavioral, emotional, or psychiatric response triggered by a precipitating event. The person may be at risk of harm to self or others, disoriented or out of touch with reality, functionally compromised, or otherwise agitated and unable to be calmed. If this crisis is left untreated, it could result in a behavioral health emergency). Individuals who believe they are in crisis are encouraged to call for help. The provider then assesses the situation and responds appropriately, to serve individuals in the least restrictive setting possible.

The SMHA data and analytical focus are often on collecting and summarizing information to provide to the legislature and less on using this data for managing the performance of providers. This is partly a result of the indirect contractual relationship with providers.

The SMHA has been collecting crisis system data at an aggregate level to look at trends and changes. They track call center service utilization by client demographics, call abandonment rates, call response times, time on call, etc. Since the ASOs have a contractual relationship with the providers, the performance of the providers is managed by the ASOs and not at the state-level. The state does set some of the terms of the ASOs contracts with providers and uses data to amend contracts to improve service provision. The SMHA does not have an existing crisis service registry though they are developing one that will collect client-level data. With client-level data, they will have a greater ability to measure performance.

The crisis line is currently and has previously been monitored through performance metrics such as incoming volume, abandonment rate, and activity duration. Currently, there is an expectation that at least 80% of calls are answered within the first minute and the abandonment rate remains 10% or lower. When, due to COVID-19 pandemic-related issues such as staff turnover and switching to working from home, the performance began to lag, the SMHA increased the resources available to the crisis line contractor.

The SMHA tracks the utilization of mobile crisis services by client demographics, frequency of use by individuals, and location of where the services were provided, and analyzes for trends. One of their goals is for mobile services to reach clients where they are and not serve people in places where there are already available mental health services, such as at schools.

Colorado tracks the performance of less than 24-hour crisis walk-in centers and the more than 24-hour crisis residential facilities, including looking at length of stay and tying length of stay to diagnoses. They have also looked at the availability to accept law enforcement drop-offs and whether the centers are pre-screening individuals to rule them wrongly out of services. It is expected that walk-in centers be able to receive and process anyone.

The SMHA has used data to update its follow-up requirements to keep people served at an outpatient level with more wraparound services. The requirement changed from follow-up with individuals at one- and five-days post-discharge to one, three, and ten days post-discharge. They are tracking the success of this update, but it was too early at the time of the interview to determine its success.

For states just starting to build crisis data systems, Colorado suggests that robust relationships are between all community partners, including setting performance and outcome standards. Without defining performance expectations and defining success, a program cannot determine success just through aggregate data reporting. It is also important to clearly define the data you are expecting your providers to collect otherwise they may default to lumping much of their data into the “Other” category.

Colorado – Signal Behavioral Health

Signal Behavioral Health Network (Signal) is contracted by the state of Colorado to provide crisis services in three regions covering the Boulder-Denver metro area along with outlying areas that are either in the mountains or on the plains. Their region’s mental health crisis care continuum includes a statewide call center, managed by an entity independent of Signal Behavioral Health, mobile crisis teams, crisis stabilization units, and in-home and facility-based crisis respite services. In the past year, crisis services for children and youth have begun to get more attention with consideration for how to better serve the unique needs of this population.

The call center is responsible for dispatching mobile crisis teams and they provide telephonic crisis and peer support to callers across the state of Colorado. The agency contracted to administer the call center also operates the national suicide prevention hotline in Colorado. Signal manages but does not operate the providers of crisis services, including the mobile crisis teams, the walk-in center, crisis stabilization units, and the respite service providers. Of the calls received for their regions by the statewide call center, only about one percent result in the dispatch of a mobile crisis team or a referral to a walk-in center. There are between 500 and 600 calls per month statewide to the call center.

As the contracted administrator of the crisis services in Denver region, Signal Behavioral Health operates as a representative of the state, and is responsible for crisis services statewide. Signal collects data from the providers that document their activities, such as the number of people served, types of episodes, etc. That data is forwarded to the SMHA.

Signal uses data to look at service trends by provider, such as changes in use patterns. For example, when children started to go back to school following the outbreak of the COVID-19 pandemic, the call center experienced an influx of calls from and related to adolescents. Signal is required by contract to

develop performance plans for the providers in their region and seeks to understand what providers are doing and experiencing to help the provider better manage their activities, such as suggesting staffing or programmatic changes. Signal receives episodic and aggregate data from their providers but not claims data. When collecting data from their various providers, Signal is at the mercy of the providers' data systems, which vary in what and how data are collected.

Signal is not in a position to manage the overall mental health service system in their regions since those operate largely independently from the contracts that Signal oversees. It is often the case that the providers Signal oversees are also providers of non-crisis mental health services but it often happens that a person in crisis receives services from providers who are not their normal service providers and therefore may have access to little information about the individual whose crisis they are trying to resolve.

To reduce the use of 911, emergency rooms, and law enforcement when addressing individuals in crisis, Signal contracts with a private ambulance company to transport the small number of individuals seen by mobile crisis teams who need higher intensity services. Without the ambulance, the mobile crisis team would have to involve either law enforcement or emergency rooms, dispatched by 911 to transport the individual to facility-based care such as a crisis stabilization unit, respite facility, psychiatric inpatient care, or withdrawal management.

The crisis stabilization facilities in the regions that Signal manages do not operate as walk-in centers, as these are currently distinctly separate services in Colorado. Some of the facilities require medical screens and often not the same medical screen by all facilities before they admit individuals. The requirement for medical screening, which can include glucose, COVID-19, and pregnancy testing, has been adopted by facilities out of an abundance of caution. The caution is in part a result of the architecture of the facilities, which do not have sally ports for Law Enforcement to drop off individuals. The facilities try to avoid what otherwise would be a mix of all ages, from children to adults, and levels of intensity of behavioral needs.

Delaware Division of Substance Abuse and Mental Health

Delaware's adult crisis service system within the Division of Substance Abuse and Mental Health, includes crisis call centers, mobile crisis teams, 23-hour receiving centers, and two crisis respite centers (for supports over 24 hours in duration), was established more than forty years ago. The system is operated and staffed by state employees and is connected to their electronic bidirectional referral system, Delaware Treatment & Referral Network (DTRN), powered by OpenBeds. There is a separate, parallel crisis service system that services youth because, in Delaware, youth in need of mental health services are served by a separate state agency.

Adult crisis services are divided regionally into two crisis service teams. The call center staff are integrated with the mobile crisis teams, meaning that the crisis team members who respond to calls at the call center are also the ones who would travel to any person in crisis, if that is deemed necessary.

That means that a person in crisis who receives mobile crisis services will be visited by the person who took their call. Crisis services are staffed by trained mental health professionals and peers.

Delaware uses a broad, person-centered definition of a mental health crisis. An individual is in crisis if that individual feels that they are in crisis. Whether or not a caller is visited in person is dependent on the presented level of dangerousness. If the crisis is not dangerous, a mobile response would depend on whether the situation warrants such a response and the availability of the team members to travel. The crisis teams use OpenBeds to arrange appointments for people in crisis. The crisis teams can also connect callers with the mental health professionals who are most familiar with the person, assuming that they are available, and the caller is previously connected to care.

Delaware currently collects call center data through paper-based call logs. The information in the logs is aggregated into a spreadsheet then reported to the Division's headquarters that use that information to track whether the call centers are meeting their goals. The state is in the process of digitizing this data collection. Using a centralized database, the state can look up whether those individuals are already in care and whether or not they are attending their appointments.

Delaware uses a data dashboard to track the operations of its crisis service system. Included in their dashboard is the ratio of calls into the crisis service system versus calls out, such as calls to providers, the hospital diversion rate, and the types of services provided, including case management, counseling, medication checks/medication monitoring, psychiatric evaluations, screening, transportation, and wellbeing checks. Targets have been set for the measures and the SMHA tracks how well their system achieves those goals. Currently, Delaware has been meeting their goals. Of all the items tracked, Delaware considers response time the most important measure.

At the call center/mobile crisis team level, the state tracks incoming and outgoing calls, including the number of such calls, the response times, and the interval between the initial call and the arrival of a mobile team. Outgoing calls are calls made by the crisis team staff including to the police or the service provider who typically cares for the individual in crisis. The SMHA tracks the number of responses, the resolution of the crisis, the number of types of responses, calls by senior citizens age 62 years and older, detentions/no detention, and voluntary admission/no admission.

Crisis team members must have mental health screener certification, which requires a 40-hour training course to complete a 24-hour detention, meaning that the team members will have detained someone for no more than 24 hours. The state does not have specific hiring goals that address cultural competency and diversity, but they do convene culturally diverse hiring panels. Spanish is the predominant second language in Delaware and, as of this writing, there are no crisis team members who are fluent in Spanish. Workforce recruitment challenges are not unique to but exist in Delaware, especially challenges hiring staff who are fluent in languages other than English. To bridge language gaps, crisis team members use the computerized Language Line service.

The Delaware Division of Substance Abuse and Mental Health also have a partnership with the Delaware State Police. As a result of this partnership, several police stations furthest from a call center are staffed with a mental health professional, who goes out on calls during the evening shifts. The pilot locations will soon launch a pre-arrest diversion program, collaboration between the SMHA, the State Police, and the Delaware Department of Justice. This pilot program was more a result of an interest in collaboration between the State Police and SMHA and the amenability of the particular police station than a result of using data to determine unmet need.

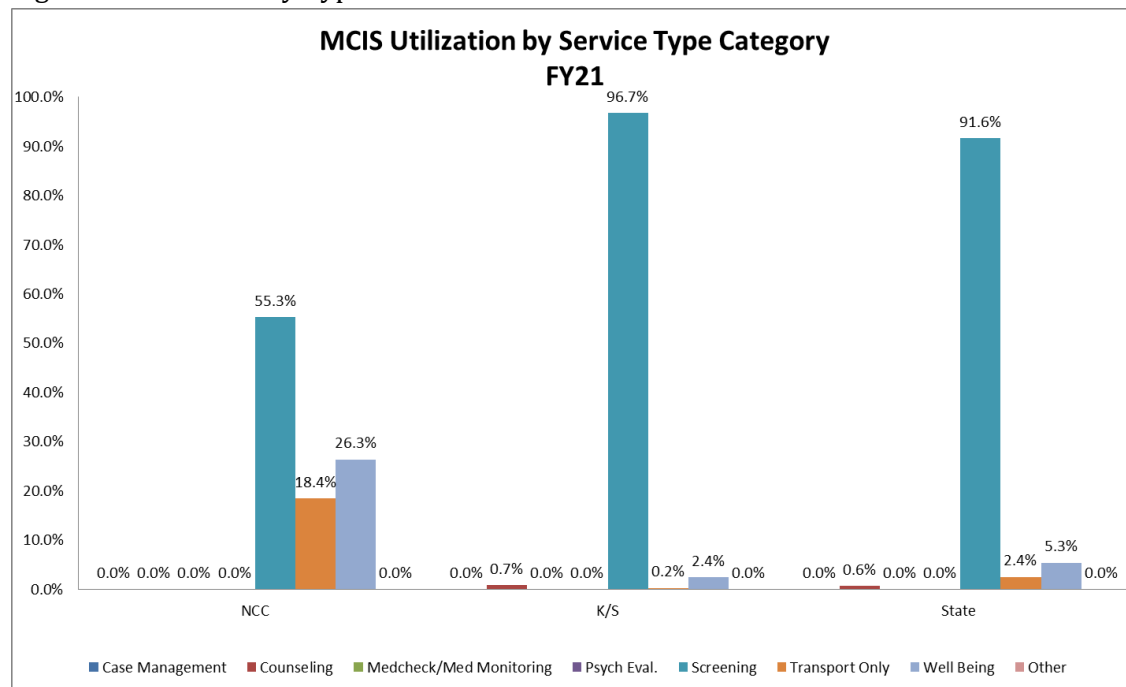
Currently, two 23-hour crisis stabilization centers are contracted but not operated by the state. Delaware is currently renewing the contract. The new contract will add a third such center to one of the three total counties, which currently does not have such a center. The success of these centers is, in part, determined by looking at the number of people admitted to a crisis stabilization center who do not end up requiring hospitalization.

There are two, greater than 24-hour crisis respite centers each with three to four beds. These beds are largely used by people who were previously at one of the two 23-hour centers. As with the 23-hour centers, Delaware look at the number of people admitted who do not end up requiring hospitalization to determine their success.

In addition to the previously mentioned crisis services and the separate and parallel youth crisis service system, there is also Lifeline, the suicide prevention hotline.

Crisis services in Delaware are not currently billed but are provided regardless of insurance or ability to pay. They can track how much the services are costing the state and what the cost per client is.

Figure 2: Utilization by Type of Service



For states just starting to build a crisis data system, Delaware, whose system has been in place for more than forty years suggests that states should track response time, the total volume of calls, and the ratio of mobile crisis responses to the total number of calls.

Georgia Department of Behavioral Health and Developmental Disabilities helped develop the Crisis Now model of mental health crisis services and has continually worked on this endeavor for many years. Accordingly, they use a broad definition of a mental health crisis, meaning they allow the individual to define their crisis. The state runs a central crisis call center that coordinates access to care for all individuals, not just those in crisis. The call center is connected to a service registry which allows for individuals to be connected to treatment at a variety of levels, including mobile crisis services, but also for non-crisis services. In addition to mobile crisis teams, the call center can connect individuals with their Assertive Community Treatment (ACT) team, assuming they are receiving ACT services, and even dispatch ACT team staff to the individual in crisis. The crisis call line is available 24 hours a day, seven days a week. Additionally, there is a peer-run warm line that is available from 8:00 a.m. to 8:00 p.m. The goals of the system are to connect people to treatment in such a way that the incidence of crises is minimized and the individuals are served in the most helpful way possible.

To achieve their goals, Georgia's SMHA has a robust service registry that not only connects people to treatment at all levels, from community services to inpatient services, but the registry also helps Georgia collect data at a state level to manage its crisis service system.

The SMHA receives daily, weekly, and monthly reports that help them actively manage their system. For example, they receive daily reports of the volume of calls, weekly reports on items such as the call abandonment rate, the average speed to answer, which is broken out by types of callers. Since their call center is used for non-crisis purposes and not just to respond to crises, they have known callers, such as clinicians, who use the system to place individuals in care at a variety of levels of intensity. Monthly, they get reports on the average speed to answer a call, the abandonment rate, and the hold-time. The hold time or time a caller is placed on hold is an important metric for them because their goal is to be as responsive as possible.

These data reports are used by Georgia to manage their system. For example, when they found that they had a high hold time, they used their data to figure out what factors were causing callers to be put in on hold and then made changes to their system to improve their efficiency and the caller experience. They implemented a voice recorder that would break into the hold music and provide information to callers. To address hold times on calls, they changed the way that the staff handed calls off to clinicians, so the staff remains with the caller as they are waiting to hand them off to a clinician. Additional staff was required to better handle the volume of calls more rapidly. The system is experiencing a staffing shortage. To inform their staffing decisions, Georgia has analyzed when their call centers are the busiest (Mondays) and least busy (Sundays except for Mother's Day).

To manage their mobile crisis teams, Georgia looks at the response times, specifically whether teams respond to calls in a reasonable time, crisis response cancellation rates, linkages to treatment, referrals types, service denial types, and repeat crisis interactions with the same individuals. Their goal is a diversion to less intensive levels of treatment for 85% of mobile crisis responses. They also look at the staffing of the mobile crisis teams, including whether not unfilled positions are open for longer than 12 weeks. The data they collect has helped provide them with an understanding of service trends, such as areas with high incidence rates, trends for service requests by time of day and day of the week. They use the data and their analyses to work with their providers to better inform staffing decisions.

In most cases, Georgia's less than 24 hour and greater than 24 crisis facilities are the same facilities. To manage this level of care, they collect a lot of data and use a variety of regular and ad hoc reports. Their goal is for their facilities to improve how they serve their communities. They look at care denial rates, occupancy rates, diversion to lower levels of care, and length of stay, among other measures. Before they propose opening a new facility, they seek to make sure that their existing facilities are used most effectively.

Overall, Georgia uses their data to create forecasting models to identify what parts of its system should change to better meet the needs of its constituents. Their robust service registry allows them to understand service usage at all levels of care provision, including their capacity and the utilization of that capacity.

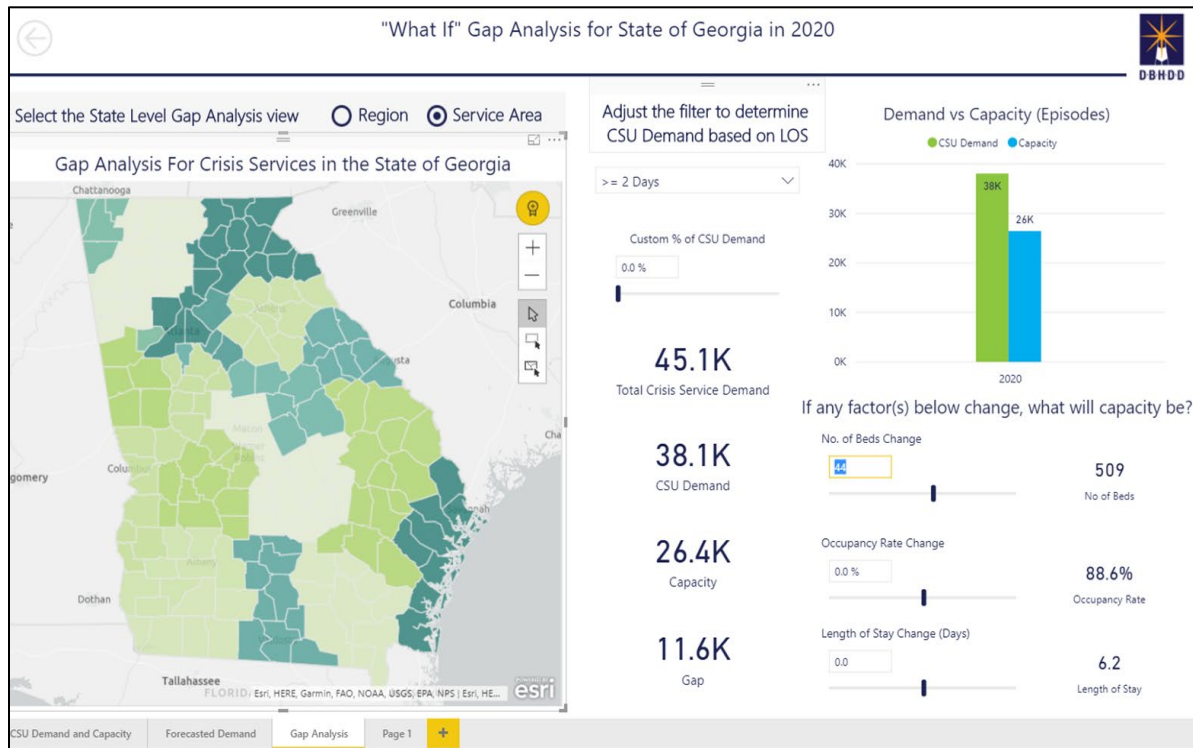
For states starting out in creating a more robust crisis service system, Georgia recommends that they focus on knowing what problems they are trying to fix. For Georgia, the most fundamental issue for them was to optimize the use of their existing services. The overall integration of their services in a service registry that can connect people to treatment and tracks the use of treatment service capacity allows them to continually work to improve their system and not just address possibly momentary crises. To create the analyses used to inform the management of the system, they have found it very beneficial to have data analysts. Their data can inform decision making. Making changes necessitates analyzing the consequences as part of a continuous process of improvement.

As robust and extensive as Georgia's data collection system is, there are still areas where they would like more information. Their system was not built overnight and is the result of additions and subtractions based upon their experience. They would like to have more information on how involuntary commitments, are made and the appropriateness of these commitments. They would also like to track recidivism more closely to determine what is driving recidivism rates and how they could change their system to improve these rates.

Figure 3: Georgia Mobile Crisis Response Services Dashboard



Figure 4: Georgia: "What If" Gap Analysis for Crisis Services



Georgia –Southwest and East-Central Regions

NRI spoke with representatives of the Southwest and East-Central regions. Southwest serves a largely rural population while East-Central serves a mix of rural and urban populations. The regions are overseen by state personnel who work in coordination with the agency's central administration as equal partners.

Georgia's approach to management, including at the regional level, is that they focus on the goal of providing services at all levels of intensity to their constituents most efficiently and appropriately possible. They work with providers to understand their needs and concerns and help providers from the various parts of the crisis service continuum collaborate to better accomplish their goals. Providers are encouraged to share what is working and what is not work so that all can benefit from the experience.

The regions use data to look at trends and to solve glitches. There are regular meetings, temporarily interrupted due to the COVID-19 pandemic. These meetings are still occurring but have shifted from in-person to virtual meetings.

Though the call center is a statewide entity, rather than regional, the call center interacts with local providers. If that interaction is not running as smoothly as desired, for example, if there are long wait times, that information is relayed to the central administration for them to address with the call center.

The regional managers have monthly meetings with the mobile crisis teams to review their activities, such as response time and number of calls. They help the crisis teams better manage their activities by identifying cyclical trends or any other issues that have arisen either within the teams or in the interaction of the teams with other providers, such as hospitals. If a particular hospital is determined to be overcalling the mobile crisis team, which causes stress to that part of the system, they will work with the hospital to retrain them on the appropriate and intended use of crisis teams.

In Georgia, the less than 24-hour and more than 24-hour crisis respite facilities are generally the same facility. The regional managers meet with these facilities with the mobile crisis teams to foster a better understanding of the system and thereby improve the relationship between these different service providers. For example, in the past, there has been a misunderstanding by the centers that they were shouldering more of the burden of providing crisis services than they were. Using data, a regional manager was able to show that 90% of mobile crisis calls result in the individual staying in the community rather than coming to a respite center.

The mobile crisis providers, who are not state employers rather contractors, meet quarterly with law enforcement in their region, providing the Law Enforcement with continuing education credits to inform them about how the crisis system operates. They begin the meetings with a presentation that shows what is being done, where people are being served, what needs to be done, and how law enforcement fits into the crisis service continuum. These meetings have been temporarily suspended due to the pandemic.

The regional managers work to make sure that their stakeholders understand the workings of their system so that the stakeholders can use it as intended. However, the system is designed to be flexible

and its design is informed by information and experience. They are always open to change if that change better achieves the overall goal of the system. For example, it became apparent that there were differing, non-standardized understandings of the definition of autism. When that issue was identified, the state better defined that data element. The providers are encouraged to feel that they are partners with the state agency and with other providers. The state uses any feedback provided to them to make changes to their system.

Oklahoma – Grand Lake Mental Health Center

Grand Lake Mental Health Center (GLMHC) serves twelve counties in northeast and northcentral Oklahoma with a population of 480,000 and covering 10,000 square miles. The region is rural, but they have 22 clinics in the twelve counties.

Grand Lake is very good at collecting and using data. They believe everything they do should have an attached data point, and that their data should be used. As a result of their rethinking of the provision of all services, not just crisis services, they have reduced hospitalization by 80-98%, depending on how the reduction is estimated. The implementation of their reimagined service system was more than paid for by the cost savings that their new system realized. They have also saved time and money for local law enforcement by drastically reducing their travel and wait times as they bring people in crisis in for services. They have also reduced jailings by making it easier for law enforcement to transport people in crisis to treatment than to jail them.

Grand Lake has been able to achieve these successes by creating a service system that can provide treatment to individuals, whether they are in crisis, whenever they want it and wherever they are.

The basis of Grand Lake's system is their crisis service centers which can individuals in voluntary services as well as those under an emergency detention order. Their goal is for there to be a crisis service center no more than 45 minutes from any individual in their 10,000 square mile region. While they have not yet met this goal, they are on the way to meeting it. Since many people in crisis are transported by law enforcement, they try to locate their crisis centers close to sheriff's offices, which reduces transport time for law enforcement. Grand Lakes tries to transport people voluntarily because they have found that if you eliminate a person's resistance, you can immediately start their recovery. More than 95% of the people they transport volunteer to be transported. Grand Lake also works very closely with law enforcement to encourage their willing participation in the Grand Lake's treatment delivery processes.

Individuals in crisis begin their treatment as they are being transported to a crisis center. This is possible because Grand Lake sponsored the development of the MyCare App, when loaded onto an iPad it puts the iPad into a single app Mode, making it, in their opinion, the "perfect Mental Health machine." This app connects an individual with a clinician the moment they encounter a peace officer and can be used as they are being transported as there is a GLMHC iPad in every law enforcement vehicle in the 12 counties they serve. A GLMHC iPad is given to individuals when they are discharged from the Urgent Care facilities for their future use, reducing crisis transports and instances of relapse. Grand Lake pays for the data fees and quality for a reduced rate as first responders. The distribution of the iPads with the

MyCare App began with the individuals who have the most need because they reasoned that the greatest benefit, and therefore cost savings, could be realized by better serving the individuals most frequently in need. The savings realized from this group funded the more widespread distribution of iPads to people less in need. Currently, more than 5,000 iPads have been distributed. They have found that it was easier to get buy-in from stakeholders once they were able to demonstrate their initial successes.

Individuals with iPads can access services, or arrange for appointments, whenever they want to, even if they are out of the region on vacation. Their no-show rate for appointments has declined. They have reduced hospitalization. There is no on-hold with the app. The app connects individuals with staff at the crisis centers. Since the crisis center staff are already at work, there are no extra personnel needed to staff the telehealth available with the app. If an individual in crisis does not already have an iPad with the app and is in crisis, they can contact a 24-hour crisis line and a mobile team can go out and meet the individual. After the COVID-19 pandemic began, Grand Lake was well prepared to provide contactless mental health treatment. For example, to reduce potential COVID-19 exposures they even delivered iPads to people at their home.

Grand Lake has been successful at achieving its goals of reducing hospitalizations and improving the cooperation of law enforcement because they have approached achieving their goals with an open mind and with data. Data serves the purpose of quantifying their situation and documenting the success or failure of the systemic changes they try. For example, they began with more than 1,100 inpatient hospitalizations per year. To reduce hospitalizations, they created new levels of care, the crisis service centers. They measured the inpatient hospitalizations and the use of the crisis centers. They found that, within five years, hospitalizations were reduced by 80-98%. The reduction of hospitalizations did not result in increased use of the crisis centers. The use of the crisis centers also decreased. They were also able to document the mileage and hours saved by law enforcement. Since the state was paying for the law enforcement's mileage used to transfer individuals to treatment, Grand Lake was also able to calculate those cost savings. There are likely other cost savings in addition that were not calculated, such as the time saved from long waits in emergency departments by law enforcement.

Grand Lake has not only used data to reduce hospitalizations but also has focused on improving the overall health of the individuals they serve... When clients are at the crisis centers, full laboratory studies are available to examine appropriate levels for psychotropics as appropriate, but also do examine medical issues. For example, providers are able to take basic lab tests to look at cholesterol levels and assess for urinary tract infections. When the COVID-19 pandemic began, they started tracking the impact of the pandemic on their clients.

Leadership at Grand Lake are invested in ever improving outcomes. For example, there has been discussion regarding examining data around suicides. Another consideration is in ensuring that they provide a comprehensive Mental Health System that treats people in the least restrictive environment, which in turn will prove to be the least expensive. By bringing technology and agencies providing services together, it is also hoped that people in need of mental health services will receive them, rather

than be routed to the criminal system. Mobile technology has been an innovation at Grand Lake that is helping services tip toward solutions.

Utah Division of Substance Abuse and Mental Health Treatment Services

The Division of Substance Abuse and Mental Health Treatment Services has been transitioning its crisis service continuum towards the Crisis Now model and is expanding the availability of crisis services in the areas served by their 13 local mental health authorities that contract with the state. Crisis services are mandated to be available statewide 24 hours a day, seven days a week. There is one crisis hotline and a warmline that cover the entire state. Mobile crisis teams are covering all of Utah's regions and the crisis walk-in facilities adhere to the Crisis Now model that includes policies of no refusal. Individuals decide whether or not they are in crisis and the system responds to their specific needs. Their goal is for services to be available statewide with response times of half an hour for law enforcement and one hour for the mobile teams in the more densely populated areas of the state and within two hours in the rural areas.

Utah uses the data collected by their system to track how people move through the continuum of crisis and what happens to them and how responsive the crisis system is to the needs of their users. Among the data elements they use to track the use of their system is the duration of calls to the crisis line, as well as the time it takes for a call to be answered.

Staffing the call center with only clinical staff has proven financially challenging, and impractical given general workforce challenges in recruiting and retaining clinicians across the state. Thus, leaders from Utah are considering other models that might be equally effective. For example, they were able to determine that clinicians tended to spend longer with users on the phone and engaged with callers as they might in therapy. Review of processes and practices indicated that for crisis call responders, it may be more prudent to identify the current, and future, services needs of that user. Call center staff will continue to be required to be appropriately trained, but they will not need to also be clinicians. The mobile crisis teams consist of a peer and a clinician in the denser populated areas and at least a peer and a case manager in the rural areas.

In monitoring the success of the different parts of their crisis service continuum, Utah is primarily concerned with referral rates. For example, how many mobile crisis team visits did calls to the crisis call center generate, and how many users were either stabilized as a result of the services provided on the call or if they were connected to community services. Their goal is to treat people in the least restrictive manner possible and preferably at home.

The state uses data to track where mobile crisis teams were referred by the call centers but were not available to make the call, either because of staffing or resource issues. In some cases, the team that is referred is not always the closest to the person in crisis.

When monitoring the work of the crisis receiving centers, Utah looks at the time it took for law enforcement to drop off a person in crisis because they do not want law enforcement to perceive their interactions with the centers to be burdensome. Utah tracks the rate of diversions from jails. They track

how long someone is at the center and if they are there for longer than 23 hours, why they remained, and then when they leave, they track whether they left, be it a hospital, detox facilities, residential treatment, or back home. Utah also collects data on what the perceived alternatives to the crisis centers are. Their goal is to help their system meet the needs of the people they serve by identifying service or resource gaps.

Utah is also interested in knowing what other states are doing to address crises in their communities so that they might adopt or adapt the successes of others to better Utah's system.

Utah recommends that any state just starting to build a crisis data system collect data on the number of calls made to crisis call lines broken out by the number of callers who remained in the community, including at home, as compared to the number who needed a higher level of care. Utah's goal is that 70% of callers remain in place.

While Utah uses data to manage its crisis service system, the state leaders in crisis services realize that not all data are useful. For example, they collect some data points that have few responses or data that do not appear to be accurate, for example, response time by mobile crisis teams to the destination. They continue to examine the reliability and accuracy of the data to engage in further refinements in data collection to help inform practice...

Washington

Washington's crisis service system is organized regionally. The regional Administrative Service Organizations (ASOs) are either based in a single county or are based in a cluster of counties that have joined together to provide services. The State Mental Health Authority contracts with the ASOs for crisis and non-Medicaid paid services. Medicaid services are purchased through Medicaid and are provided by five large Managed Care Plans. The MCOs purchase crisis services through the ASOs for managed care enrollees.

Each region has a centralized call center; some regions also have warm lines. Multiple regions have crisis triage/stabilization facilities. These facilities are licensed to hold people for more than 24 hours but are also used for stays of less than 24 hours. Each facility has the capacity for police drop-offs. Typically police drop-offs are held for up to 12 hours for evaluation.

The regions also have mobile crisis teams. Until this year, there was no state-level definition of a mobile crisis team. In one region, a team might be defined as two individuals who can go out on calls, and the region would report having multiple teams for 24/7 response. In another region, a team would consist of the entire crisis responder staff and could be 20 or more individuals. The SMHA is developing a statewide definition for crisis teams for accurate capacity tracking.

Washington's system includes involuntary treatment for people in crisis. The regions have designated crisis responders who evaluate people for involuntary treatment. In rural areas, those people may also be a member of the mobile crisis team responding to a call. In those cases, the mobile crisis team members announce to the individual that they will be assessing them for involuntary treatment and everything that they said to them previously will not count as part of the determination but everything

said subsequently will be. The assessments are a quasi-legal procedure rather than a clinical intervention. These crisis responders have the authority to put people on five-day, involuntary holds. Later, individuals placed in involuntary treatment can be held for up to 90 days through hearings convened by local Superior Courts.

The SMHA has for decades collected a substantial amount of data on the involuntary treatments, which comes to them in a timely manner. The data include the date and time of the encounter, the outcomes of the investigations, and the legal criteria used for detention determinations. They track this by region, including looking at outliers related to the number of investigations and the outcomes. A separate dataset tracks the hearings, including how many people make it to court within 48 hours, how many cases are dismissed, how many are sent to less-restrictive alternatives, and how many are committed for 14 or 90 days.

Washington's crisis service system is undergoing change and expansion due to factors which include the Trueblood Decision, legislative action expanding crisis services, the future roll-out of 988 services, and the creation of a broad service registry to link people to care at all levels of intensity. The Trueblood lawsuit challenged the delays in competency evaluation and restoration services for people in jail. The court ordered the state to provide such evaluations within 14 days and competency restoration within seven days of court orders.²⁶

To determine the cost of expanding the availability of crisis services, including expanding the number of crisis teams, the SMHA needed to create a standard definition of a crisis team, which they then costed out. In the new definition, a crisis team consists of 11 people, including a supervisor. The new definition allows for two people to be in the field, including one peer and one behavioral health professional) with service available year-round and 24 hours per day. They are also able to calculate per person service costs. Previously, the regions were reluctant to provide the state with information about their workforce because they were afraid that their workers would be recruited by other regions. The promise of expanding capacity allayed those fears. As a result of calculating the costs of providing crisis services, the SMHA determined that Medicaid billing will not cover the cost of providing crisis services. The legislature understands that the expansion of crisis services purchases availability and coverage rather than individual services.

In the past, they looked to the regions to monitor the success of the crisis services they provided. The regions had an incentive to provide effective services because they would be fiscally responsible for paying for any involuntary treatment. The state did track the number of crisis calls received by the regions but did not connect that data to outcomes data. In the future, the SMHA will be legislatively required to track the performance of the crisis service systems run by the ASOs.

With the future rollout of 988 services, the call centers will be able to connect with the service registry that is under development. The recently passed 988 bill provides for call center staff to be able to find out if individuals have Advance Directives or under current involuntary treatment orders.

Additional data that would help manage the crisis service system would include the disposition of calls to the crisis system, including the ability to link information that identifies callers with the involuntary

treatment investigations. It would also be helpful if the data collected in the future could allow for the assessing risk for each call. Data should constantly be analyzed to address the needs of their constituency, however; if data are not used then their collection should be discontinued.

Washington Olympic Health and Recovery Services (Thurston and Mason Counties)

Olympic Health and Recovery Services (OHRS) are a county-governed, publicly funded licensed Behavioral Health Agency (BHA) that provides crisis services to Thurston and Mason counties, Washington. Thurston has a population of 300,000 and has rural and urban areas while Mason is rural and has a population of about 65,000. Olympic Health and Recovery Services responds to about 400 crisis outreaches per month, 80% of which are in Thurston County, and conducts about 250 involuntary assessments per month (see the section above for a discussion of Washington's involuntary assessment activities).

They are not the sole crisis service provider in their region and the services are not always coordinated amongst the various providers. They have zero relationship with the regional National Suicide Prevention LifeLine (NSPL) call center located 100 miles away. Olympia, the state capitol, the county seat of Thurston County, operates their non-licensed crisis team using city funds in collaboration with OHRS, who co-locates a responder on their team 40 hours per week. The local ASO, contracts with Catholic Community Services to provide separate 24/7 youth mobile outreach services.

In Washington, most regions use a contracted call center. In this case, Olympic operates its own 24/7 call center. As in Delaware, clinical staff operate the call center and are part of the mobile crisis teams responding to those calls, when needed. Calls are triaged, however, if the call came from a hospital, they have to send out staff who can make involuntary commitment decisions, otherwise, normal staff can respond. Only 12% of the calls result in an involuntary commitment determination. Staff also reach out to individuals for up to 14 days after a mobile crisis visit.

While they do not operate crisis stabilization centers, they do provide stabilization services, but in the individual's home. The stabilization outreach program is peer staffed and responds to an average of 55 clients per month. They go to the individual's home, stay with them, talk with them, and try to connect the individual with resources to address their needs. Crisis stabilization outreach began in November 2020 and so, at the time of the interview, they did were not able to determine if the program was successful in diverting individuals from hospitals.

One of Olympic's largest problems is staffing. Washington's involuntary commitment rules require a high-level staff but recruiting and retaining higher-level staff is difficult. Since the vast majority of crisis calls do not result in involuntary commitment, Olympic added lower-level staff, including certified peers, who are fully capable of taking care of the lower-intensity calls.

Lack of information on the clients they serve is a problem that Olympic experiences. In 2020, as a result of a reorganization of Medicaid funding in Washington, Olympic no longer received information on Medicaid-funded clients, who are about 60% of the people they serve. Olympic does not have access to

the local emergency department information exchange and often does not have any information on the person they are responding to, including their medical history or family information. Many of the individuals they provide crisis services have crisis plans but they no longer have access to those plans. Though access to crisis plans is required by the state, no mechanism exists to make sure that the access happens. Since many of the crisis calls happen in the middle of the night, they are not able to contact the individual's normal providers to find out information about the individual's medical history.

Olympic collects their data to track and manage their operations. They are interested in knowing what the overall service needs in their communities are and how they are meeting that need and so collect response time, referral source, demographic information, law enforcement calls by law enforcement agency, etc. Each of the law enforcement entities in their region has different protocols and responds differently to crises so knowing which law enforcement entity they will encounter on a crisis call is important to know to resolve the situation most effectively. They use time of day to track trends and use that data to influence staffing decisions. They have used response time to referrals to expand the staffing of their crisis teams. During the COVID-19 pandemic, they experienced an increase in crisis calls. Increasing their crisis service staff did not result in a decrease in involuntary commitments, which, to them, means that even with the increase in service capacity; they are still not meeting the service needs of their community.

Figure 5: Olympic Health and Recovery Services Crisis Service Report Template

		BH-ASO			
		Crisis System Metrics Report			
BH-ASO					
Contact Person					
Phone Number					
Email					
Reporting Period (quarter/year)					
Metric Number	Metric	Month 1	Month 2	Month 3	Quarter Total
Crisis Calls					
1a	Total number of calls to crisis line				0
1b	Total number of calls to crisis line answered				0
1c	Average answer time of calls to crisis line (seconds)				#DIV/0!
1d	Total number of calls to crisis line answered live within 30 seconds				0
1e	Percentage of calls to crisis line answered live within 30 seconds	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
1f	Total number of calls to crisis line abandoned				0
1g	Percentage of calls to crisis line abandoned	#DIV/0!	#DIV/0!	#DIV/0!	#DIV/0!
Mobile Crisis Outreach Services					
2a	Total number of mobile crisis outreach services				0
2b	Percentage of EMERGENT mobile crisis outreach service requests/referrals that were responded to within two (2) hours				#DIV/0!
2c	Percentage of URGENT mobile crisis outreach service requests/referrals that were responded to within twenty-four (24) hours				#DIV/0!
Involuntary Treatment Act (ITA) Investigations					
3a	Total number of ITA investigations				0
3b	Total number of ITA investigations conducted via telehealth				0
3c	Total number of ITA investigations not meeting detention criteria, resulting in a referral to outpatient treatment				0
3d	Total number of ITA investigations not meeting detention criteria, resulting in a referral to voluntary inpatient treatment				0
3e	Total number of ITA investigations resulting in detention or revocation				0
3f	Total number of ITA investigations resulting in detentions or revocations filed as SUD				0
3g	Total number of ITA investigations resulting in detentions or revocations filed as MH				0

Figure 6: Olympic Health and Recovery Services Crisis Service Data Definitions

Crisis Calls	
1a	Total number of calls to crisis line. <i>Definition: All Calls received by regional crisis line regardless of caller intention or if sufficient information is gathered to generate an H0030 encounter.</i>
1b	Total number of calls to crisis line answered. <i>Definition: Number of calls answered by a live person.</i>
1c	Average answer time of calls to crisis line (seconds). <i>Definition: Average answer speed for calls that are answered by a live person (1b). This does not include wait times for abandoned calls.</i>
1d	Total number of calls to crisis line answered live within 30 seconds. <i>Definition: Total number of calls answered by a live person (1b) <30 seconds</i>
1e	Percentage of calls to crisis line answered live within 30 seconds. <i>Definition: (Total calls answered by a live person <30 seconds) / (Total calls answered). (1d / 1b). Note: use two decimal places e.g. 98.75%</i>
1f	Total number of calls to crisis line abandoned <i>Definition: Number of calls that result in hang up after 30 seconds (including those who hang up during an automated attendant script)</i>
1g	Percentage of calls to crisis line abandoned <i>Definition: (Calls abandoned) / (Total number of calls to crisis line) (1f / 1a) Note: use two decimal places e.g. 4.75%</i>
Mobile Crisis Outreach Services	
2a	Total number of mobile crisis outreach services. <i>Definition: Crisis services provided by eligible provider type (H2011-SERI) in response to a crisis outreach referral. Referrals can originate from any source, including but not limited to, crisis call lines, community members, health care professionals, law enforcement, family members, or by individuals in crisis (self-referral). This excludes Involuntary Treatment Investigations.</i>
2b	Percentage of EMERGENCY mobile crisis outreach service requests/referrals that were responded to within two (2) hours. <i>Emergent Definition: Mobile Crisis Outreach Services provided for a person that, if not provided, would likely result in the need for crisis intervention, or hospital evaluation due to concerns of potential danger to self, others, property, or grave disability.</i> <i>Definition: (EMERGENCY requests/referrals responded to in two (2) hours or less) / (Total number of EMERGENCY requests/referrals). Note: use two decimal places e.g. 98.75%</i>
2c	Percentage of URGENT mobile crisis outreach service requests/referrals that were responded to within twenty-four (24) hours. <i>Urgent Crisis Definition: Mobile Crisis Outreach Services to be provided to persons approaching a behavioral health crisis. If services are not received within 24 hours of the request, the persons situation is likely to deteriorate to the point that emergency care is necessary.</i> <i>(URGENT requests/referrals responded to in twenty-four (24) hours or less) / (Total number of URGENT requests/referrals) Note: use two decimal places e.g. 98.75%</i>
Involuntary Treatment Act (ITA) Investigations	
3a	Total number of ITA investigations. <i>Definition: All crisis encounters where a Designated Crisis Responder conducts an ITA investigation whether or not the outcome is a detention. All encounters coded as H2011HW.</i>
3b	Total number of ITA investigations conducted via telehealth. <i>Definition: The total number of ITA Investigation (3a) conducted via telehealth</i>
3c	Total number of ITA investigations not meeting detention criteria, resulting in a referral to outpatient treatment. <i>Definition: The total number of ITA Investigation (3a) not meeting detention criteria, resulting in a referral to outpatient treatment.</i>
3d	Total number of ITA Investigations not meeting detention criteria, resulting in a referral to voluntary inpatient treatment <i>Definition: The total number of ITA Investigation (3a) not meeting detention criteria, resulting in a referral to voluntary inpatient treatment.</i>
3e	Total number of ITA investigations resulting in detention or revocation. <i>Definition: The total number of ITA Investigation (3a) resulting in detention or revocation.</i>
3f	Total number of ITA investigations resulting in detentions or revocations filed as SUD. <i>Definition: The total number of ITA Investigation resulting in detention or revocation (3e), filed as SUD.</i>
3g	Total number of ITA investigations resulting in detentions or revocations filed as MH. <i>Definition: The total number of ITA Investigation resulting in detention or revocation (3e), filed as MH.</i>

Conclusion

Management is the process of dealing with or controlling things or people. Management decisions can be informed by evidence, necessity, feelings, whim, accident, and even changes in the political environment. Decisions can have intended and unintended consequences, improve things, make things worse, or have no impact. This paper argues that the most successful management decisions are a) intended to improve something, b) based upon evidence that informs the decision, c) part of a continuing management process of improvements, and d) undertaken with the understanding that actions have consequences that also should be studied and understood. Information used to inform decisions should be relevant to the management decisions they will be used for and collected as accurately as possible. Data about state mental health programs are often collected as documentation, reported by local providers to the SMHA and by SMHAs to the Federal Government, as part of the block grant reporting, to legislatures.

As this report shows, local providers and SMHAs are using data to manage the provision of mental health crisis services. The extent to which data are used, and the provision of services is managed, varies by state. Some local providers and SMHAs use an ad hoc approach while some use a continual improvement approach.²⁷ In some states, the SMHA has a very indirect relationship with service providers where the services providers are contracted by a local entity which, itself, has a direct relationship with the SMHA. In such a case, the SMHA manages the provision of services by documenting the fulfillment of the guidelines and procedures that the SMHA establishes and occasionally, often at the beginning of a new contract, alters. In some states, the local entities also have indirect relationships with service providers and the management of services is similar to that of SMHAs with indirect service provider relationships.

When a local agency or state manage and provide services directly, there are many opportunities to use data to inform management decisions. Grand Lake in Oklahoma, for example, directly operates services. Using a continual improvement approach, they have reimagined service provision, documented their successes and failures, and used data to further alter their activities. Similarly, Georgia's SMHA runs the state's crisis service system and has direct relationships with the service providers. Georgia also uses a continuous improvement approach to alter their activities. Any individual change that is made using a continuous quality improvement approach may or may not be a success, and may or may not have a large impact. Still, the accumulation of improvements over the years, even small improvements, can add up vast improvement and broad systemic change that can result in better services for the people who need them, when they need them.

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