



988

Convening Playbook
States, Territories, and Tribes

NASMHPD

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Overview

Goal. The document sets out to help:

- Identify operational readiness for 988 through self-assessment
- Help states, territories, and tribes prepare for the 988 transition (not a specific mandate for them)
- Explain how to make progress on the criteria that are central to 988 readiness
- Identify best practices and examples seen in the field today

Audience. The document is written for:

- State / territory directors of mental health and substance use services
- Tribal leaders with responsibility for mental health and substance use services

Structure. The document is structured in four sections:

- I. Operational readiness self-assessment for states, territories, and tribes
- II. Playbook for states and territories
- III. Playbook for tribal nations
- IV. Additional resources

Notes:

- *Equity:* The playbook aims to highlight equity considerations across topics, including how equity needs to be considered across all areas of readiness
- *Case studies and examples:* The playbook includes many case studies and examples from different states, territories, and tribes. However, the examples will not be applicable to all states, territories, and tribes

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I. 988 operational readiness self-assessment for states, territories, and tribes

Introduction and purpose of the operational readiness self-assessment

The self-assessment tool is intended to assist states, territories, and tribes in assessing their readiness for the July 2022 transition to 988 and prioritizing areas of focus moving forward.

The tool is not intended to be evaluative and no responses will be collected or aggregated. There is neither a *perfect score* nor a *right answer*. The intent is solely to help states, territories, and tribes determine where they might focus efforts both ahead of July 2022 and beyond as the country moves toward integrated crisis care.

In addition, there is no time expectation associated with the self-assessment tool. States, territories, and tribes are working in different contexts and all have different priorities and needs related to 988 and integrated crisis care. The goal of this self-assessment tool is to help states, territories, and tribes define an aspiration unique to their locality, not prescribe any activities on a specific timeline.

Self-assessment levels

The self-assessment tool lays out a series of criteria within specific readiness categories that are aimed at holistically capturing components of readiness to realize the full potential of 988. For each criterion, three distinct levels can be selected. States, territories, and tribes are asked to select the level that best approximates their current state.

- Beginning: Work in this area has not yet started
- Emerging: Work in this area is underway but not yet complete
- Solidified: Objectives in this area are fully or almost fully met

Link to playbooks

The self-assessment categories match categories of information contained in the rest of the playbook document. The results of the self-assessment can be used to determine which areas of the playbook to consider focusing on in the immediate term.

For example, states, territories, and tribes who are “beginning” work within specific categories that they believe are important can use information contained in the playbook to chart a path and initiate activities aimed at achieving “emerging” readiness. States that are

already “emerging” in certain categories can use information in the playbook to fully solidify their readiness in those categories.

Criteria

Several of the following criteria refer to “**specific populations**” that need to be consulted and considered when building crisis systems. Specific populations are groups that have been historically underserved, underrepresented, and/or have a higher risk of experiencing mental health and substance use crises. These groups include but are not limited to: Black, Indigenous, and people of color (BIPOC); LGBTQ+; tribal members; veterans; children and adolescents; older adults; the chronically ill and disabled; people with lower incomes; people with language needs (e.g., American Sign Language (ASL), Spanish); and people living in rural areas.

Criteria identified as priorities for July 2022

Criteria	Beginning	Emerging	Solidified
<u>LIFELINE CONTACT CENTER CAPACITY</u>			
What percent of projected calls are answered in the state / territory? ¹	State / territory will not have capacity to handle at least 90 percent of calls by April 2024	State / territory will have capacity to handle at least 90 percent of calls by April 2024	State / territory already has an in-state / in-territory answer rate of 90 percent
To what extent does the state / territory have a plan to achieve 24/7 primary coverage for calls state- / territory-wide? ²	There is not a plan to achieve state- / territory-wide 24/7 coverage by July 2022	There is a plan in place to achieve state- / territory-wide 24/7 coverage by July 2022	State / territory already has 24/7 primary coverage for Lifeline calls
To what extent does state / territory have text / chat capabilities?	No Lifeline contact centers currently have chat / text capabilities, and there is no plan in place for at least one contact center to have these capabilities by July 2022	No Lifeline contact centers currently have chat / text capabilities, but there is a plan in place for at least one contact center to have these capabilities by July 2022	At least one Lifeline contact center currently has chat / text capabilities

¹ Criteria based on target in-state answer rates identified by SAMHSA.

² Criteria based on Vibrant Core Areas Instructions for State 988 Implementation Plans.

Criteria	Beginning	Emerging	Solidified
What percent of chats / texts receive in-state / territory response ? ²	State / territory is not expected to have capacity to handle at least 50 percent of chats / texts by July 2023	State / territory will not have capacity to handle at least 50 percent of chats / texts by July 2022 but will have capacity to handle 50 percent of chats / texts by July 2023	State / territory will have capacity to handle at least 50 percent of chats / texts by July 2022 and 80 percent of chats / texts by July 2023
To what extent does the state / territory have a plan to achieve 24/7 primary coverage for chats / texts ? ²	There is not a plan to achieve state- / territory- wide 24/7 primary coverage for chats / texts by July 2023	There is a plan in place to achieve state- / territory- wide 24/7 primary coverage for chats / texts by July 2023	There is currently state- / territory-wide 24/7 primary coverage for chats / texts
To what extent does the state / territory have a plan to achieve 24/7 backup coverage for calls state- / territory-wide ? ²	There is not a plan to achieve state- / territory-wide 24/7 backup coverage by July 2023	There is a plan in place to achieve state- / territory-wide 24/7 backup coverage by July 2023	State / territory already has 24/7 backup coverage for Lifeline calls
To what extent does the Lifeline contact center network have resources and contact centers dedicated to supporting tribal members ?	There are no tribal contact centers or tribal resources within the state	Lifeline contact centers within the state can refer tribal members to resources only within the state	Lifeline contact centers within the state have a process to refer tribal members to resources within the state and across state lines
CRISIS CARE & BEHAVIORAL HEALTH CARE CAPACITY ³			
To what extent has the state / territory conducted an inventory of available crisis response services ? ⁴	No inventory has been conducted regarding which crisis response and rescue units exist within the state / territory	State / territory has identified which crisis response and rescue units exist within the state / territory, but has not established an integration plan across available crisis response and rescue units	State / territory has identified which crisis response and rescue units exist within the state / territory, and has established an integration plan across available crisis response and rescue units

³ States/territories can assess each criterion in the crisis care and BH care capacity section separately for adults and youth. Behavioral healthcare follow-up care should be able to respond to mental health and SUD crises.

⁴ Crisis response and rescue units that operate within states/territories include (but are not limited to) MCTs, mobile co-responder teams, crisis intervention teams and law enforcement, emergency medical services, fire responders, peers, community response teams, and federal and tribal organizations.

Criteria	Beginning	Emerging	Solidified
How is the state / territory working with crisis response and rescue units in the crisis care continuum? ⁵	No plan to work with crisis response and rescue units to initiate a behavioral health (BH) response to a BH crisis and divert individuals to an integrated crisis care system when feasible	Planning underway to work with crisis response and rescue units to initiate a BH response to a BH crisis and divert individuals to an integrated crisis care system when feasible	Plan in place to work with crisis response and rescue units to initiate a BH response to a BH crisis and divert individuals to an integrated crisis care system when feasible
What percent of the population has access to timely mobile crisis services (≤ 1 hour urban, ≤ 2 hours rural)? ⁵	Fewer than 50 percent	50-75 percent	More than 75 percent
How many mobile crisis response teams are available for every 1,000,000 population members (in an urban setting)? ⁶	Fewer than four	Four to six	Over six
How many mobile crisis response teams are available for every 1,000,000 population members (in a rural setting)? ⁶	Fewer than six	Six to nine	Over nine
What percent of the population has access to a no-wrong-door crisis receiving center within a 45-minute drive / transport in an urban setting ?	Fewer than 50 percent	50-75 percent	More than 75 percent
What percent of the population has access to a no-wrong-door crisis facility services within a 45-minute drive / transport in a rural setting ?	Fewer than 50 percent	50-75 percent	More than 75 percent
How many no-wrong-door crisis receiving center chairs are available for every 1,000,000 population members? ⁷	<22	22 to 33	33+

⁵ Mobile crisis capacity and responses may leverage telehealth models.

⁶ "Crisis Resource Need Calculator," Crisis Now, accessed February 2022, <https://crisisnow.com/tools/>.

Criteria	Beginning	Emerging	Solidified
What percent of the population has access to Substance Use Disorder (SUD) crisis services ?	Fewer than 50 percent	50-75 percent	More than 75 percent
What percentage of the population has access to same-day (outpatient) follow-up care ?	Fewer than 50 percent	50-75 percent	More than 75 percent
COMMUNICATIONS & EXTERNAL ENGAGEMENT			
To what extent has the state / territory conducted an inventory of which organizations / individuals should be engaged to support 988 ?	No inventory has been conducted regarding which organizations / individuals should be engaged to support 988	State / territory has identified which organizations / individuals should be engaged to support 988 but has not established a plan to interact with stakeholders	State / territory has identified which organizations / individuals should be engaged to support 988 and has established formal arrangements to partner with stakeholders
What is the state's / territory's strategy for a 988 marketing campaign to educate organizations / individuals ?	No capacity or plan to develop marketing campaign by 2023 or guidance given by state / territory for the marketing campaign	Capacity and/or plan in place to develop marketing campaign by 2023, but state / territory has given guidance to postpone the marketing campaign	Documented marketing strategy / campaign developed to educate organizations / individuals about 988 and will be initiated in the first year of 988
How will the state / territory target specific populations as part of a 988 outreach campaign?	No plan in place to target specific populations as part of a 988 outreach campaign	Plan in place for targeted messaging for specific populations through limited channels (e.g., state website) as part of a 988 outreach campaign	Plan in place for targeted messaging for specific populations through multiple channels as part of a 988 outreach campaign
How will the state / territory engage with organizations that work with specific populations as part of a 988 outreach campaign? ⁷	No plan in place to engage with organizations that work with specific populations as part of a 988 outreach campaign	Plan in place to engage organizations that work with specific populations as part of a 988 outreach campaign	State / territory has already engaged with organizations that work with specific populations to support / contribute to the 988 outreach campaign

⁷ Organizations that support specific populations include but are not limited to: advocacy organizations, mental health and SUD providers, Medicaid agencies and health plans, federal and tribal organizations, food banks, and homeless shelters.

Criteria	Beginning	Emerging	Solidified
To what extent has the state / territory planned to finance a statewide / territory-wide 988 communications campaign based on Vibrant's projected contact volumes?	No budget identified or funding in place for 988 communications	Budget identified for 988 communications but awaiting appropriation	Budget identified and funding secured for planned 988 communications
To what extent has the state / territory collaborated with tribes regarding the 988 transition?	No outreach / engagement with tribes about 988	State / territory has indirectly engaged with tribes (e.g., a post on state website, one-way communication) on 988 transition	State / territory is collaborating with tribes regarding 988 (e.g., multi-way communications, partnerships)
To what extent has the state / territory designated a tribal liaison to engage with tribes on behalf of the state / territory regarding 988 and integrated crisis care?	No liaison has been designated to engage with tribes	The state / territory has designated a liaison, but the liaison has had limited engagement with tribes	The state / territory has designated a liaison, and the liaison is working with tribes on 988 and integrated crisis care
To what extent has the state / territory collaborated with Indian Urban Health programs to provide services for tribal members?	No outreach / engagement with Indian Urban Health programs	There has been some engagement with Indian Urban Health programs, but scope of services to be provided is unclear	State / territory is collaborating with Indian Urban Health programs and there is a plan to provide crisis services to tribal members
To what extent has the state / territory collaborated with tribes to develop a strategy for a 988 marketing campaign to educate tribal nations on 988?	No collaboration to develop a strategy to educate tribes statewide on 988	There has been some collaboration with tribes to develop a strategy to broadly educate tribes on 988 within the state	There has been extensive collaboration with tribes to develop a strategy to educate all tribes on 988 using culturally appropriate language
To what extent is the state / territory aware of federal versus state jurisdictions within the state / territory (as related to federal trust lands like tribal reservations)?	The state / territory is not fully aware of federal jurisdictions within the state / territory	The state / territory is aware of federal jurisdictions within the state / territory, but there are no formal agreements for state entities to access federal trust lands to provide mobile crisis services for tribal members	The state / territory is aware of federal jurisdictions within the state / territory, and there are formal agreements for state entities to access federal trust lands to provide mobile crisis services for tribal members

Criteria	Beginning	Emerging	Solidified
How is the state / territory working with tribes to coordinate a mobile crisis response on reservations?	No engagement with tribes to coordinate a mobile crisis response on reservations	State / territory has engaged with tribes to coordinate a mobile crisis response on reservations, but no formal arrangements are in place	State / territory has engaged with tribes to coordinate a mobile crisis response on reservations and has established formal arrangements to do so
<u>INTEGRATING LIVED EXPERIENCE INTO CRISIS SYSTEMS</u>			
To what extent are people with lived experience included in the planning and implementation of 988 coalitions? ⁸	People with lived experience are not included in the planning and implementation of 988	People with lived experience are informally involved or underrepresented in the planning and implementation of 988	State / territory has engaged in bi-directional communication with people with lived experience in the planning and implementation of 988
To what extent does the state / territory have a program to include trained peers in crisis services? ⁹	No plan to increase the role of trained peers in crisis services	State / territory has a plan to increase the role of trained peers in crisis services (e.g., established process to credential / train peers)	Peers are already actively working in crisis services
<u>FINANCIAL SUSTAINABILITY</u>			
What short-term funding strategy is in place to cover Lifeline contact center operating costs?	Funding for 988 is insufficient to cover contact center operating costs for July 2022	Contact center funding is sufficient to cover projected contact center operating costs through July 2023	Contact center funding is sufficient to cover projected contact center operating costs beyond July 2023
To what extent has the state / territory conducted a financial inventory to finance 988 and integrated crisis care , if current funding strategy is insufficient to cover costs?	No financial inventory has been conducted	Portion of potential sources have been reviewed, but financial inventory is not fully comprehensive	Comprehensive financial inventory of all potential funding sources has been conducted

⁸ People with lived experience should reflect their communities and the populations they serve. They can also include families of people with lived experience.

Criteria	Beginning	Emerging	Solidified
To what extent has the state / territory conducted a financial assessment of how to fund 988 and integrated crisis care for tribal nations if current funding strategy is insufficient to cover costs?	No financial inventory has been conducted	Portion of potential sources have been reviewed, but financial inventory is not fully comprehensive	Comprehensive financial inventory of all potential funding sources has been conducted
To what extent is the state / territory aware of which tribes are eligible for crisis services provided by the state?	The state / territory is unaware which tribes are eligible for crisis services provided by the state / territory	The state / territory is aware of some but not all tribes that are eligible for crisis services provided by the state / territory	The state / territory is aware of all tribes that are eligible for crisis services
What long-term funding strategy is in place to cover Lifeline contact centers (after July 2023)?	No funding strategy or plan to finance Lifeline contact centers	Funding strategy or plan to finance Lifeline contact centers, but insufficient to cover all operating costs	Funding strategy or plan in place to fully finance Lifeline contact centers
What long-term funding strategy is in place to cover mobile crisis team (MCT) costs ?	No funding strategy or plan to finance MCTs	Funding strategy or plan to finance MCTs but insufficient to cover all operating costs	Funding strategy or plan in place to fully finance MCTs
What long-term funding strategy is in place to cover crisis receiving facility and short-term crisis bed costs ?	No funding strategy or plan to finance crisis receiving facility and short-term crisis beds	Funding strategy or plan to finance crisis receiving facility and short-term crisis beds but insufficient to cover all operating costs	Funding strategy or plan in place to fully finance crisis receiving facility and short-term crisis beds
To what extent is the state / territory mental health administration collaborating with the state Medicaid agency on community-based mobile crisis planning grants ?	No engagement with the Medicaid agency on mobile crisis planning grants	The state / territory is in the initial phase of working with the Medicaid agency regarding mobile crisis planning grants	The state / territory has engaged the Medicaid agency regarding mobile crisis planning grants and has clear direction on implementation
LEGISLATION & OVERSIGHT			
To what extent has the state / territory established the infrastructure and oversight to support 988 and integrated crisis care?	Crisis services supporting 988 and crisis care operate as individual units	988 and integrated crisis care have been implemented and are overseen at the country level, but is not supported state- / territory-wide	988 and integrated crisis care have been implemented and are overseen at the state- / territory level

Criteria	Beginning	Emerging	Solidified
To what extent has the state consulted and communicated with tribal nations to identify challenges associated with implementing 988 in Indian Country?	No formal interaction and/or outreach with tribal nations to identify and address challenges associated with 988	Informal or non-exhaustive interaction and/or outreach with tribal nations to identify and address challenges associated with 988	State has provided formal guidance (potentially as part of legislation) on how to identify and address challenges associated with implementing 988 and ensuring access to care for tribal members
To what extent are tribes included in the planning and implementation of 988 coalitions (e.g., tribal leaders, citizens, Indian Urban Health programs)?	Tribes are not included in the planning and implementation of 988	Tribes are informally involved or underrepresented in the planning and implementation of 988	State / territory has engaged in bi-directional communication with tribes in the planning and implementation of 988
TECHNOLOGY			
To what extent can real-time regional bed registry technology be accessed by crisis stabilization service providers?	No real-time bed registry or system in place to identify available beds	Access to real-time bed registry or system in place to identify available beds in immediate area	State- / territory-wide access to real-time bed registry or system in place to identify available beds
To what extent can state / territory contact centers schedule outpatient appointments ?	Contact centers within the state / territory cannot schedule outpatient appointments	Some but not all contact centers within the state / territory can schedule outpatient appointments	All contact centers within the state / territory can schedule outpatient appointments
DATA & PERFORMANCE MANAGEMENT			
To what extent does the state / territory have the ability to monitor data across the crisis continuum ?	State / territory does not have the ability to monitor data	State / territory can monitor data for a subset of entities within the crisis continuum (e.g., public but not private entities)	State / territory can monitor data across all entities within the crisis continuum
How are contact volumes and performance metrics for Lifeline contact centers tracked and projected at the state / territory level?	No system to track / project 988 contact volumes and assess performance	System to track / project 988 contact volumes and assess performance at the call center level (no standard system across the state / territory)	Standard system to track / project 988 contact volumes and assess performance across all call centers within the state / territory with aggregation at the state / territory level

Criteria	Beginning	Emerging	Solidified
How are contact volumes and performance metrics for MCTs tracked and projected at the state / territory level?	No system to track / project patient volumes and assess performance	System to track / project patient volumes and assess performance at the MCT level (no standard system across the state / territory)	Standard system to track / project patient volumes and assess performance across all MCTs within the state / territory with aggregation at the state / territory level
How are contact volumes and performance metrics for crisis receiving facilities tracked and projected at the state / territory level?	No system to track / project patient volumes and assess performance	System in place to track / project patient volumes and assess performance at the facility level (no standard system across the state / territory)	Standard system to track / project patient volumes and assess performance across all crisis receiving facilities within the state / territory with aggregation at the state / territory level
How are outcomes measured to ensure all populations are receiving access to crisis services state- / territory-wide?	Outcomes are not being measured	Outcomes are being measured but lack demographic data to assess outcomes for specific populations	Outcomes are being measured and include demographic data
What processes are in place for measuring 988 and crisis system Key Performance Indicators (KPIs) at the individual, population, and system levels, and for supporting performance improvement and corrective action ? ⁹	No KPIs or performance improvement / corrective action processes established	KPIs and performance improvement / corrective action processes established and measured, but not at the state / territory level	State / territory defines KPIs and performance improvement / corrective action processes for the crisis system
To what extent does state / territory have continuous training and improvement programs in place to ensure crisis services meet the needs of specific populations and respond to a broad range of mental health / SUD-related crisis calls?	No continuous training and quality improvement (QI) programs in place	Continuous training and QI programs in place at the unit level	Continuous training and QI program guidance provided by the state / territory; performance improvement process is overseen at the state / territory level

⁹ KPIs may be different for public and private entities.

Criteria	Beginning	Emerging	Solidified
TRIBAL NATIONS¹⁰			
To what extent has the tribal nation engaged with federal and state partners to coordinate 988 and integrated crisis care efforts?	No outreach / engagement with federal and state partners about 988 and integrated crisis care	Tribe has engaged with federal and state partners, but does not have a plan to coordinate 988 and integrated crisis care	Tribe has engaged with federal and state partners and has a plan to coordinate 988 and integrated crisis care
To what extent has the tribal nation identified a representative to engage with external organizations on behalf of the tribe regarding 988 and integrated crisis care? ¹¹	No representative has been designated to engage with external organizations	Tribe has designated a representative but has not identified the external organizations with which the representative should engage	Tribe has designated a representative and understands which external organizations to engage
To what extent has the tribal nation communicated internally with its members on 988 and how to access care?	No outreach / engagement with tribal members about 988 and integrated crisis care has been conducted or planned	Tribe has communicated or plans to communicate internally with its members about 988 and integrated crisis care through limited channels	Tribe has communicated or plans to communicate internally with its members about 988 and integrated crisis care through a broad range of channels
To what extent has the tribal nation established a relationship with 988 and crisis care services (Lifeline contact centers, rescue units, care facilities) to communicate the needs of the tribe?	No relationships have been established with 988 services	Tribe has established informal relationships with at least some of the 988 services available to the tribe	Tribe has established formal relationships with all 988 services available to the tribe
To what extent has the tribal nation conducted a financial inventory to finance 988 and integrated crisis care for the tribe and its members?	No financial inventory has been conducted	Portion of potential sources have been reviewed, but financial inventory is not fully comprehensive	Comprehensive financial inventory of all potential funding sources has been conducted
To what extent does the tribal nation have access to mobile crisis and/or rescue units on the reservation?	Tribe has limited access / no formal arrangements with any mobile crisis and/or rescue units	Tribe has access to mobile crisis and/or rescue units through informal arrangements only	Tribe has access to mobile crisis and rescue units through organic Tribal services or other formal arrangements

¹⁰ The Tribal Nations section of the *988 Operational Readiness Criteria for States, Territories, and Tribes* is a set of criteria tribes can use to evaluate and potentially act on their own readiness as it relates to 988 and crisis care. The special government-to-government relationship between the federal government and tribes is based on the Constitution, has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders, and reaffirms the right of Indian tribes to self-government and self-determination.

¹¹ Organizations that support 988 and crisis services on behalf of tribes include but are not limited to Indian Urban Health programs, state / territory BH authorities, state / territory 988 planning coalitions, Lifeline contact centers, rescue units, and care facilities.

II. Playbooks for States, Territories, and Tribes

1. Lifeline contact center capacity

The transition to 988 is expected to result in a significant increase in the volume of Lifeline calls, chats, and texts. This increase in volume underscores the critical role of states / territories in ensuring that the needs of all individuals are met through 24/7 in-state coverage of all calls, chats, and texts by Lifeline contact centers.¹² According to Vibrant’s User Guide, with the 988 transition, “state / territory support for Lifeline / 988 crisis centers and related services is essential” to enable Lifeline operators to provide support to callers and link callers to other crisis services.¹³

Per Vibrant’s milestones, all states / territories will have ensured the following by **June 30, 2022**:

- There is 24/7 primary coverage by in-state Lifeline contact centers for Lifeline / 988 calls
- There is SOME level of coverage for Lifeline / 988 chat / text provided by in-state Lifeline centers

By **June 30, 2023**, all states / territories will have ensured:

- There is both statewide and territory-wide 24/7 primary and backup coverage for every county by in-state Lifeline member crisis contact centers for 988 calls
- There is 24/7 coverage for 988 crisis chat / text provided by in-state Lifeline centers

States / territories play a central role in meeting the milestones to ensure sufficient call / chat / text coverage. They have taken a number of approaches to increase their Lifeline contact center capacity by:

- Providing state funding for 988 and crisis care
- Enabling remote work capabilities for crisis contact centers
- Monitoring coverage and performance standards of contact centers
- Implementing contact center pooling strategies

Providing funding for 988 and crisis care

Case study: State funding for Lifeline in Utah¹⁴

Utah uses State General Fund dollars that were appropriated by the Utah State Legislature. In FY21, Utah’s landscape analysis included \$2.7 million as total funding for

¹² Vibrant Emotional Health, “Vibrant Core Area Instructions – 988 Implementation Plan,” accessed February 2022.

¹³ Vibrant Emotional Health and Education Development Center, User Guide – 988 Implementation Plan, accessed February 2022.

¹⁴ “988 Implementation Plan for Utah,” State of Utah 988 Planning Grants, accessed February 2022.

the National Suicide Prevention Lifeline (NSPL) funding. Additional general funding to support lifeline contacts was secured in preparation for 988 through its SB155 988 legislation, and an additional allocation of \$1.3 million for FY22 was allocated to the Huntsman Mental Health Institute's Crisis Line (which operates the statewide Lifeline number). These allocations represent ongoing funding. In FY21, total funding supported 113,685 contacts, 18,845 of those being calls answered when routed from the NSPL.

By FY23, Utah estimates that \$8.9 million will be allocated to the state's crisis line and lifeline affiliate. This ongoing funding is 100 percent dedicated to answering calls for the crisis hotline, including calls initiated by the NSPL, and follow-up services for the entire state. According to Lifeline's estimated costs, no gaps in funding for FY22 or FY23 are expected given expanded the funding Utah's Legislature allocated.

The legislatively-appointed Behavioral Health Crisis Response Commission has agreed to continue supporting the use of general fund dollars and to explore a 988 fee at a later date (if needed), should the general fund be unable to sustain the crisis programs that have been identified as priorities.

Case study: State funding for lifeline in Washington¹⁵

The Washington State legislature passed a stopgap measure to increase the in-state call answer rate and follow-up capacity for the NSPL. This dedicated funding has since been sustained on an annual basis to support this work, which helped create a virtual call center in January of 2018 comprised of two NSPL-member centers in Washington State (Crisis Connections and Volunteers of America of Western Washington).

These centers received NSPL calls from all of Washington's 39 counties, including those which previously had not possessed a crisis center to answer local calls made to the Lifeline. This additional funding and the creation of the virtual line increased Washington's in-state answer rate from 41 percent to 78 percent in just 18 months. Call volume to the NSPL from Washington State also increased about 40 percent over that same period.

While the funding provided in the 2017 stopgap measure was limited (Washington had an annual statewide budget of ~\$347,000), the state saw significant improvements in the significantly improved in-state answer rate and increased utilization of NSPL services by its citizens. As a result, more funding was available in 2020 (\$915,000). Prior to Washington's 988 legislation (HB 1477), this budget was the state's only dedicated funding for NSPL services. For additional information on HB 1477 fees and scope of services, see ["Overview of states that have enacted a 988 fee" in Legislation and Oversight section.](#)

¹⁵ "988 Implementation Plan for Washington," Washington State 988 Planning Grants, accessed February 2022.

Enabling remote work capabilities for crisis contact centers

Case study: Enabling remote work capabilities in Nebraska¹⁶

Nebraska transitioned to a 60 / 40 remote-to-on-site staffing model in March 2020. The contact center and customer service management systems, including quality assurance, supervision, and support of these systems, is fully remote capable. All on-site and remote workforce receive the same pre-service and continuing education training, which meet the Lifeline Call Center standards and those for accreditation with the American Association of Suicidology. Since transitioning to a hybrid work structure, quality and productivity measurements have been consistently achieved across on-site and remote counselors and information security and privacy standards have been maintained.

To sustain its hybrid structure's effectiveness, Nebraska made creating and maintaining a strong culture for its on-site and remote workforces a priority. To do this, it outlined clear standards and expectations for remote operations and emphasized the importance of communication among all staff. The state also reinforced contact center operations by ensuring their technology met performance standards for remote operations and that all counselors received the support they need to perform at their best. These contact center remote-work options not only responded well to COVID-19, they also helped the contact centers remain competitive in the current staff recruitment environment.

Monitoring coverage and performance standards of contact centers

Case study: monitoring coverage in New Jersey¹⁷

As of spring 2022, New Jersey has five Lifeline member centers. Two of these receive funds from the Division of Mental Health and Addiction Services (DMHAS) in the New Jersey Department of Human Services. All five Lifeline centers have expressed interest in being part of the 988 system. In summer 2022, DMHAS will use a procurement process to make funds available for a Managing Entity for 988, which must be or become a Lifeline approved center.

Funds allocated to participating Lifeline centers from federal grants will be used to build capacity for the projected 988 call / chat / text volume. The Managing Entity will ensure all centers meet and maintain Lifeline and DMHAS performance and operational standards, and will ensure that all centers are Lifeline-approved as well. This will guarantee that the minimal clinical standards of all the DMHAS-contracted agencies align with those established by Lifeline.

¹⁶ Interview with Sheri Dawson, Director, Division of Behavioral Health Community Based Services, U.S. Department of Health and Human Services, February 2022.

¹⁷ "988 Implementation Plan for New Jersey," New Jersey 988 Planning Grants, accessed February 2022.

The Managing Entity will also manage data collection for the state, and maintain the ongoing delivery of appropriate information to leadership at Vibrant Emotional Health (the administrator of the NSPL). It will also be responsible for the collection and delivery of any additional data requirements Lifeline and/or DMHAS deem necessary. Any additional data collection requirements from the state will be developed in consultation with the Managing Entity and delivered as appropriate.

Pooling resources to increase Lifeline contact center capacity

Many states / territories are looking for innovative ways to increase their Lifeline contact center capacity to meet the anticipated volumes expected with the transition to 988. Pooling combines contact center operators and counselors so as to generate economies of scale and distribute capacity to effectively meet demand.

Pooling may be used to enable states / territories to increase in-state answer rates without additional resources, as well as reduce wait times and abandoned calls.¹⁸

To pursue pooling, states / territories can:

- Assess the variability and seasonality of demand by analyzing contact volumes by day, week, month, and year
- Establish processes and procedures to shift supply (e.g., using contract operators and counselors) when higher contact volumes are anticipated or demand spikes
- Work with Vibrant Emotional Health and other partners to ensure other contact centers (e.g., 211, local hotlines) are cross-trained and meet the requirements to respond to Lifeline calls
- Establish best practices so that all contacts receive consistent and quality responses across all contact centers

Example: New York reported that it is working with NYC Well, a crisis line operator, to pursue a pooled model and improve its in-state answer rate. NYC Well currently operates two simultaneous crisis lines. Merging operations could allow counselors to answer all calls in order and staff according to total call volume.¹⁹

¹⁸ Interview with Christian Terwiesch, Professor at The University of Pennsylvania's Wharton School, March 2022.

¹⁹ "988 Implementation Plan for New York," New York 988 Planning Grants, accessed February 2022.

2. Crisis care and behavioral healthcare capacity

Harnessing the full potential of 988 to transform overall crisis care will require ensuring not only that state / territories have the capacity to handle 988 contacts, but also that there is sufficient capacity in the crisis care and BH systems to meet the downstream needs of individuals in crisis and/or the family / allies of those in crisis who contact 988.

There are extensive materials available on how to develop the ideal crisis care system and innovative ways to expand BH capacity. This section focuses on determining what resources are needed to support integrated crisis care and on ways to expand the workforce to support mental health and SUD services.

Determining workforce and resource needs for integrated crisis care

Workforce and resource calculators can help estimate the optimal crisis system resource allocations needed to meet the needs of specific communities. Three examples of workforce calculators are highlighted below; each can calculate the specific resources required based on input parameters.²⁰

Use case	Calculator type	Inputs	Outputs
Calculating Lifeline contact center staffing needs to meet service levels	Erlang calculator ²¹	<ul style="list-style-type: none"> Number of phone calls Time period (e.g., per half hour) Average call duration (average handling time) Service level or percentage of calls answered within a period of time (e.g., 80 percent of calls in 20 seconds) 	Number of contact operators needed to meet the service level target
Calculating mobile crisis capacity and number of crisis beds / chairs	Crisis Now Crisis Resource Need Calculator ²²	<ul style="list-style-type: none"> Population census Average length of stay of acute inpatient Average cost of acute bed / day <i>Additional customization based on state / territory cost models can be included</i> 	<ul style="list-style-type: none"> Number of resources needed for the following: <ul style="list-style-type: none"> MCTs Acute inpatient beds Short-term beds Crisis receiving chairs Costs of resources Potential cost savings

²⁰ "National Guidelines for Behavioral Health Care – Best Practice Toolkit," Substance Abuse and Mental Health Services Administration, pg. 42, <https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>.

²¹ "Erlang calculator for call centre staffing (online version 5.0)," Callcentre helper, accessed February 2022, <https://www.callcentrehelper.com/tools/erlang-calculator/>.

²² "Crisis Resource Needs Calculator," Crisis Now, accessed February 2022.

Use case	Calculator type	Inputs	Outputs
Calculating crisis receiving and stabilizing facility staffing needs	Crisis Now Staffing Calculator ²³	<ul style="list-style-type: none"> Percentage served under involuntary commitment Percentage served via law enforcement drop-off Number of admissions per day Average length of stay Average number of seclusion and restraints per day Average program census Number of one-on-one assignments in the program 	<ul style="list-style-type: none"> Number of staff required for the following roles: <ul style="list-style-type: none"> Provider staff (e.g., psychiatrists, nurse practitioners) Nursing staff Clinicians Peer and BH workers Costs of staffing

Expanding behavioral health care capacity

The transition to 988 creates an opportunity for states, territories, and tribes to rebuild, reorganize, and expand their capacity to address the unmet need for BH services.²⁴ States are addressing the shortages of BH workers through innovative approaches, including incentive programs, training, and career pathways.

Approaches to increase peer workforce in BH services

Georgia introduced House Bill 1013, which aims to expand Georgians' access to care. Not only would the legislation increase the number of mental health professionals in the state, it would also require insurance companies to cover mental health the same way they cover physical health and to compensate mental health providers the same as other health care providers.²⁵ Parity in compensation for health services is a critical step in reversing the trend of a declining BH workforce and improving crisis care.

Colorado introduced legislation to boost the role of peer support professionals to ease a shortage of specialists who can help treat patients with mental health and addiction issues.²⁶ The bill would improve how peer support services are billed under Medicaid and expand settings where peers can provide services to include justice-involved settings and telehealth.²⁷ Providing peers access to financially sustainable careers and expanding the reach of their services increases the overall supply of BH workers within the state.

²³ "Crisis resource staffing calculator," Crisis Now, accessed February 2022, <https://crisisnow.com/tools/>.

²⁴ "Consensus approach and recommendations for the creation of a comprehensive crisis response system," Well Being Trust, November 2021, <https://wellbeingtrust.org/wp-content/uploads/2021/11/988-Crisis-Response-Report-November-FINAL.pdf>.

²⁵ Maya T. Prabhus, "Wide-ranging health bill aims to increase access to services in Georgia," *The Atlanta Journal-Constitution*, January 26, 2022, <https://www.ajc.com/politics/wide-ranging-mental-health-bill-aims-to-increase-access-to-services-in-georgia/S3N2A2PVAVHNBKVJLXRZAVYKLY/>; Dave Williams, "Ralston unveils comprehensive bill to boost mental health services in Georgia," *The Current*, January 26, 2022, <https://thecurrentga.org/2022/01/26/ralston-unveils-comprehensive-bill-to-boost-mental-health-services-in-georgia/>.

²⁶ Mental Health Colorado, "Mental health advocates introduce bill to support people in recovery and address health care workforce shortage," February 18, 2021, <https://www.mentalhealthcolorado.org/mental-health-advocates-introduce-bill-to-support-people-in-recovery-address-health-care-workforce-shortage/#:~:text=House%20Bill%201021%2C%20introduced,improvements%20to%20peer%2Delivered%20services.>

²⁷ "House bill 21-1021," Seventy-third General Assembly, State of Colorado, n.d., https://leg.colorado.gov/sites/default/files/documents/2021A/bills/2021a_1021_01.pdf; Mental Health Colorado, "Mental health advocates introduce bill," February 18, 2021.

Education incentives to expand behavioral health counselors and providers

California Department of Education is planning to speed up the credentialing process for 10,000 school mental-health counselors. It will try to entice clinicians into schools with loan forgiveness and scholarships to offset education costs, potentially reducing the time it takes for mental health clinicians to get licensed.²⁸

Massachusetts MassHealth's Student Loan Repayment Program's aim is to reduce the shortage of licensed BH professionals across the state. The program offers upwards of \$50,000 for a two-year contract for professionals with unpaid student loans working in an underserved community.²⁹

- **Additional resources:**
 - [MassHealth](https://www.mass.gov/info-details/massachusetts-loan-repayment-program-mlrp-for-health-professionals#award-amounts-) Loan Repayment Program (https://www.mass.gov/info-details/massachusetts-loan-repayment-program-mlrp-for-health-professionals#award-amounts-)

Training programs to certify behavioral health specialists

The **University of Washington's** department of psychiatry and behavioral sciences is developing a training program designed to offer talk therapy certification to undergraduates, which would help address the growing number of young people experiencing mental health issues. After completing the training, students could begin practicing under supervision as a "BH support specialist". The department received \$3.7 million to develop and implement this program.³⁰

Psychiatric Rehabilitation Association (PRA) offers the Certified Psychiatric Rehabilitation Practitioner (CPRP) credential and the Child and Family Resiliency Practitioner (CFRP) credential (which serves children and youth). Both are test-based certifications.³¹ The CPRP and/or CFRP credentials are recognized in more than 14 states. They allow service workers to provide psychiatric and/or psychosocial rehabilitation services, depending on the state. In some instances, the CPRP may substitute for a bachelor's degree in a human services field or for years of work experience.³²

- **Additional resources:**
 - [PRA](https://www.psychrehabassociation.org/sites/default/files/images/2013-State%20Regulations.pdf) State Recognition of the CPRP Credential (https://www.psychrehabassociation.org/sites/default/files/images/2013-State%20Regulations.pdf)

²⁸ Melissa Gomez, "State seeks to speed credentials for 10,000 direly needed school mental health counselors," *Los Angeles Times*, January 5, 2022, <https://www.latimes.com/california/story/2022-01-05/mental-health-crisis-counselors-pandemic>.

²⁹ "Massachusetts loan repayment program (MLRP) for health professionals," Government of Massachusetts, n.d., <https://www.mass.gov/info-details/massachusetts-loan-repayment-program-mlrp-for-health-professionals#award-amounts->.

³⁰ Taja PerryCook, "UW looks to address shortage of mental health professionals with psychotherapy training program for undergrads," *The Daily of the University of Washington*, November 30, 2021, https://www.dailyuw.com/news/discoveries/uw-looks-to-address-shortage-of-mental-health-professionals-with-psychotherapy-training-program-for-undergrads/article_e8ad03f6-51c1-11ec-a255-7357349ba31e.html.

³¹ "CPRP certification," Psychiatric Rehabilitation Foundation and Psychiatric Rehabilitation Association (PRF and PRA), n.d., <https://www.psychrehabassociation.org/certification/cprp-certification>.

³² "State recognition of the CPRP and the CFRP," PRF and PRA, n.d., <https://www.psychrehabassociation.org/cprp-certification/state-recognition-cprp-and-cfrp#:~:text=The%20CPRP%20and%20For%20CFRP%20credentials%20are%20recognized%20in%2014,Oklahoma%2C%20Pennsylvania%2C%20and%20Virginia.>

Case study: Developing career paths to grow and retain a behavioral health workforce

Behavioral Health Education Center of Nebraska (BHECN) has built and strengthened partnerships with 18 academic institutions within the state and collaborates with them on training and workforce retention.³³ Nebraska has increased the BH workforce by 33 percent in the last decade (2010-2020), but has still more demand for mental health and substance use services.³⁴

Nebraska's strategy to expand its BH workforce engages students in high school and college through BHECN's Ambassador Program, which exposes recruits to BH professions in rural and urban underserved areas. Through partnerships, legislative support, and external funding, BHECN connects students with training and internship opportunities, thus providing interprofessional training in rural and underserved areas of the state. It also supports the BH workforce throughout their careers with professional development and opportunities for connecting with colleagues. These actions promote networking and retention.³⁵

- **Additional resources:**
 - [BHECN Legislative Report](https://www.unmc.edu/bhecn/_documents/bhecn_legislative_report_fy20-21_final.pdf)
(https://www.unmc.edu/bhecn/_documents/bhecn_legislative_report_fy20-21_final.pdf)

3. Communications and external engagement

Strategic approach to 988 messaging

While messaging to the public may not begin until after July 2022, states and territories can begin planning how to engage stakeholders immediately to ensure they will have an overall 988 communications strategy in place that addresses messaging and defines the audiences who will receive the messages. This section outlines additional resources for states / territories to leverage as they further develop their plans and begin messaging.

It can be helpful to think about messaging in terms of two audiences, with disparate needs for channels, specific messages, and timing:

- Partners (e.g., state agencies, crisis services organizations, nonprofits)
- Public (e.g., individuals in crisis / recovery, family and allies, specific populations, general population, media)

³³ "Behavioral Health Education Center of Nebraska, Legislative report FY 2020 & 2021," Behavioral Health Center of Nebraska, December 2021, https://www.unmc.edu/bhecn/_documents/bhecn_legislative_report_fy20-21_final.pdf1.

³⁴ Zoey Muesel, "The Behavioral Health Education Center of Nebraska report shows increase in providers," Channel 3 KMTV News Now, December 29, 2021, <https://www.3newsnow.com/news/local-news/the-behavioral-health-education-center-of-nebraska-report-shows-increase-in-providers>.

³⁵ "Behavioral Health Education Center of Nebraska, Legislative report," pg. 4, December 2021.

Reference material to support partner messaging (timing: before July 2022)

Prior to the July 2022 transition to 988, communication is best centered on basic information about 988 and engaging with partners who play a role in BH crisis care delivery. Specific topics to consider when communicating with partners may include:

- **What 988 is, how it works, and how it fits within the broader crisis service ecosystem:**
 - 988 is the new dialing code that provides direct, life-saving services to people experiencing mental health and substance use crises—or family members and advocates of those in need—through the *existing* NSPL.³⁶ When people call, text, or chat 988, they will be connected to trained counselors that are part of the existing NSPL network. These trained counselors will listen, understand how their problems are affecting them, provide support, and connect them to resources if necessary.”³⁷
 - Additional resources for basic information on 988:
 - [SAMHSA](https://www.samhsa.gov/find-help/988) FAQ site (<https://www.samhsa.gov/find-help/988>)
 - [Vibrant](https://www.vibrant.org/988/) FAQ sites (<https://www.vibrant.org/988/>)
 - [Suicide Prevention Lifeline](https://suicidepreventionlifeline.org/current-events/the-lifeline-and-988/) The Lifeline and 988 (<https://suicidepreventionlifeline.org/current-events/the-lifeline-and-988/>)
 - [Suicide Prevention Lifeline](https://suicidepreventionlifeline.org/wp-content/uploads/2021/08/Back-to-Basics.png) How 988 calls are routed (<https://suicidepreventionlifeline.org/wp-content/uploads/2021/08/Back-to-Basics.png>.)
 - [The CEO Huddle](https://www.thekenedyforum.org/988toolkit/) 988 toolkit (<https://www.thekenedyforum.org/988toolkit/>)
- **Relationship between 988 and 911:**
 - 988 and 911 are designed to be complementary. 911 is currently used for all emergencies, including BH emergencies. However, 911 dispatchers may not be trained on how to handle these types of calls. On the other hand, 988 is a BH crisis number and 988 counselors are trained to assist people in emotional distress, suicidal crisis, or struggles with substance use. In many cases, 988 counselors can de-escalate a crisis over the phone and connect callers with community resources for ongoing support. Ongoing collaboration between 988 and 911 will help individuals in crisis get the appropriate support, potentially providing options like MCTs in place of police or emergency medical services (EMS) responders when needed and where available.”³⁸
 - Additional resources for information on the relationship between 988 and 911:
 - [CrisisNow](https://talk.crisisnow.com/embedding-crisis-response-in-harris-countys-911-dispatch-center/) Embedding crisis response in Harris County’s 911 dispatch center (<https://talk.crisisnow.com/embedding-crisis-response-in-harris-countys-911-dispatch-center/>)

³⁶ “988 suicide and crisis lifeline,” Substance Abuse and Mental Health Services Administration, n.d., <https://www.samhsa.gov/find-help/suicide-prevention/988-lifeline>.

³⁷ “The lifeline and 988,” National Suicide Prevention Lifeline, n.d., <https://suicidepreventionlifeline.org/current-events/the-lifeline-and-988/>.

³⁸ “Framework for successful messaging,” National Action Alliance for Suicide Prevention, January 21, 2022, <https://suicidepreventionmessaging.org/>.

- [Los Angeles County](http://file.lacounty.gov/SDSInter/bos/supdocs/149282.pdf) 911 alternative crisis response protocols and decision trees (http://file.lacounty.gov/SDSInter/bos/supdocs/149282.pdf)
- [Broome County](https://www.theiacp.org/sites/default/files/MHIDD/BroomeDiversion-508.pdf) 911 distressed caller distressed caller decision tree (https://www.theiacp.org/sites/default/files/MHIDD/BroomeDiversion-508.pdf)

Reference material to support public messaging (timing: after July 2022)

Communication after the transition to 988 can expand to the public once the state's / territory's readiness to support 988 is complete.³⁹ As they build the infrastructure to support 988 and crisis care, they will individually need to determine when they are ready to expand messaging to the public. Timing considerations for messaging may include:

- Messaging materials have been updated from the suicide hotline number (1-800-273-TALK) to 988
- There is sufficient Lifeline contact center capacity to meet the anticipated demand
- Connections and linkages have been established between 988 contact centers and MCTs or other rescue units to escalate care as needed
- There is sufficient BH provider and service worker capacity to respond to crisis episodes that escalate beyond contact centers and mobile response

SAMHSA is currently in the process of developing select messaging material to support engagement with the public regarding 988. In the absence of specific collateral, states / territories can refine their overall communication strategies and approaches.

The National Action Alliance for Suicide Prevention's (Action Alliance) *Framework for Successful Messaging* lays out several components for effective messaging about suicide and suicide prevention. This framework could also be used to support communications around mental health and substance use services. Components of the framework include:⁴⁰

- Be strategic and ensure there is an objective behind the messaging
- Use safe messaging by focusing on the solutions and services that exist for those who may be struggling, and reinforce solutions rather than highlighting the problem of stigma
- Use data strategically and in a prevention-focused manner
- Tailor messaging for specific populations by partnering with organizations that have extensive experience working with these groups
- Amplify messaging through ongoing engagements with local champions to advocate for crisis services and the funding of crisis systems, and to get the word out in the community

In addition, the Action Alliance is developing a 988 Messaging Framework that will provide messaging guidance around crafting public messaging about 988 and a 988 media reporting guidance one-pager (to be released in Q2 of 2022).

³⁹ "Framework for successful messaging," National Action Alliance for Suicide Prevention, January 21, 2022.

⁴⁰ "Framework for successful messaging," National Action Alliance for Suicide Prevention, January 21, 2022.

- **Additional resources:**
 - [Action Alliance](https://theactionalliance.org/task-force/988-messaging) 988 Messaging Framework (https://theactionalliance.org/task-force/988-messaging)
 - [Action Alliance](https://suicidepreventionmessaging.org/) Framework for Successful Messaging (https://suicidepreventionmessaging.org/)
 - [CDC](https://www.cdc.gov/healthcommunication/Health_Equity.html) Health equity guiding principles for inclusive communication (https://www.cdc.gov/healthcommunication/Health_Equity.html)
 - [Vibrant](https://www.vibrant.org/wp-content/uploads/2020/07/988_two_pager_2021-2.pdf) 988 and the Lifeline (https://www.vibrant.org/wp-content/uploads/2020/07/988_two_pager_2021-2.pdf)

4. Integrating lived experience into crisis systems

Peers are essential in forming meaningful connections and inspiring hope for those suffering with mental health and SUDs. Using their lived experience of recovery, they can bring a level of mutuality to crisis interventions that helps build trust and a strong therapeutic alliance. This trusting relationship helps forge a connection from the person in crisis to the rest of the service team, which increases the likelihood of effective and comforting care.⁴¹ Their ability to remain objective and non-judgmental, and to relate to those suffering, is key to providing care.⁴²

Peer supporters act as hopeful reminders to all team members that recovery happens. In addition, when individuals served realize that peer supporters are people who have recovered, they can be inspired with hope and possibilities for themselves. The underlying thought that can occur in the individuals who work with peer supporters is, “If she / he / they can do it, so can I.”⁴³

Peers offer their unique lived experience to provide support through advocacy, education, mentoring, and motivation.⁴⁴ Their involvement in designing crisis programs, serving as coaches and advocates for others experiencing mental health and substance use episodes, and providing crisis services strengthens the overall crisis care system. This section highlights the range of roles that peers play in crisis systems across states and innovative approaches states have taken to increase peer involvement.

⁴¹ Interview with Lisa St. George, Vice President Peer Support and Empowerment at RI International, February 2022.

⁴² Interview with Bradley Powers (retired) of The Burrell Center, January 2022.

⁴³ Lisa St. George et al., “Peer Employment Training,” RI International, 2019, <https://riinternational.com/listing/ri-consulting/>.

⁴⁴ “What is a peer?,” Mental Health America, n.d., <https://www.mhanational.org/what-peer#:~:text=In%20behavioral%20health%2C%20peers%20offer,and%2For%20in%20addiction%20recovery.>

Roles played by peers in crisis systems

Inclusion of peers in designing crisis systems

Peers, as co-designers of crisis services and the larger BH service system, can support the development of a more person-centered, holistic, welcoming, recovery-focused, and empowering system. Because peers typically have made use of the programs in which they now provide peer support services, they have a deep understanding of the complexities presented to people when they attempt to navigate these systems. They also have an intimate knowledge about what is helpful in systems of care, as well as aspects that may be less effective or that create gaps or barriers to recovery. Through their lived experience, peers can help states / territories build crisis systems that deliver better health outcomes for individuals, and the families of individuals, in crisis.⁴⁵

Peer-to-peer warmlines as a way to bolster crisis contact center operations

The use of peer warmlines for high-risk but not suicidal situations was found to be effective in reducing hospitalization rates.⁴⁶ In some cases, they can be a preferred means to provide emotional support for those who may be distraught and needing someone to talk to, which keeps other crisis services available to those in need of emergent services. However, peer warmline contact operators must be trained and empowered to recognize when to escalate care and transfer calls to a crisis line or mobile response, law enforcement, or EMS intervention. Properly implemented, peer-to-peer warmlines are an integral part of the crisis continuum of care and an effective way to bolster crisis contact center capacity.⁴⁷

Peers serving as coaches and mentors in crisis receiving facilities

Tennessee's Crisis Stabilization Units (CSU) operate 24/7 / 365 and provide an inpatient-like experience for those experiencing crisis. Peer Supporters who have been certified by the state provide services throughout the system of care, including the crisis stabilization units. Peers engage with patients to assist and support them on their recovery journey. Tennessee has found that through peers' living examples of recovery, they can often connect with those suffering with mental health and SUDs when others could not. Peers in Tennessee act as coaches and mentors, sharing their experiences, knowledge, and hope in a way that conveys mutual respect and accountability. When people work with someone who has lived through the experience of mental illness, substance use, co-occurring challenges, or trauma, it is an empowering experience.⁴⁸

The Burrell Center's Behavioral Crisis Center (BCC) of Missouri serves as a single-point of entry for those who are in a substance or mental health related crisis. It employs a range of BH staff and actively seeks to hire peer support specialists for its Rapid Access Unit (RAU), the front-facing treatment and screening center of the BCC. Peers are a staple

⁴⁵ Interview with Lisa St. George, RI International, February 2022.

⁴⁶ Amelia Rocco Klein, Ram A. Cnaan, and Jeannie Whitecraft, "Significance of peer social support with dually diagnosed clients: Findings from a pilot study," *Research on Social Work Practice*, Volume 8, Number 5, pgs. 529–551, September 1, 1998, <https://doi.org/10.1177/104973159800800503>.

⁴⁷ Interview with Lisa St. George, RI International, March 2022.

⁴⁸ "Crisis stabilization units (CSU)," Tennessee Department of Mental Health and Substance Abuse Services, n.d., <https://www.tn.gov/behavioral-health/need-help/crisis-services/csu.html>; Interview with Lisa St. George, RI International, February 2022.

component of patient engagement and motivation; they help lead to successful clinical outcomes.⁴⁹ Some responsibilities of peer support specialists at the Burrell Center include:⁵⁰

- Participate in treatment planning with the other team members and client
- Engage clients in a collaborative and caring relationship
- Share lived experiences to inspire and help clients by relating recovery stories
- Collaborate with clients to identify recovery practices that work for them
- Assist clients with identifying their strengths and personal resources to aid in their recovery
- Coach clients to set goals that have meaning for them, encourage clients to develop strategies to accomplish those goals, and help clients participate as a member of the recovery team

Case study: Peers serving on mobile crisis response teams

In Arizona, peers serve on MCTs alongside licensed mental health clinicians (generally masters level or above). These teams are dispatched by local crisis contact centers and public safety answering points (PSAPs) that have been approved by the state or county to dispatch mobile crisis outreach for individuals experiencing mental health and substance use crises.⁵¹ Their involvement in mobile crisis can help alleviate the fear or anxiety that may otherwise occur with a law enforcement or first responder intervention. This allows for crises to be de-escalated on scene with the MCT and supports people to remain connected to their life, families, work, and follow-on care.⁵²

Since the adoption of the peer mobile crisis model, which is primarily funded by Medicaid and supplemented by grant or state general funds,⁵³ Arizona has reduced the number of people taken to emergency departments and crisis receiving centers (CRC) by engaging individuals in crisis in the location where they feel most safe (e.g., their home or community).⁵⁴ The Emergency Mobile Pediatric Adolescent Crisis Team—Suicide Prevention Center (EMPACT-SPC) operates a 24-hour crisis hotline and MCTs, comprised of peer supporters and clinicians trained in crisis intervention, that responds to 500-600 dispatches a month. These teams are able to stabilize 75 percent of the individuals they meet in the community and refer 21 percent of the individuals to receive further care in CRCs. Only three percent require the filing of a petition for involuntary treatment in a CRC or hospital and only one percent are taken to a hospital emergency department.⁵⁵

As outlined above, peers are an important part of crisis services and deliver unmatched care to those experiencing mental health and substance use crises. They should not be seen as low-cost replacements for other important types of professionals. Peer supporters are full

⁴⁹ Interview with Bradley Powers, The Burrell Center, January 2022.

⁵⁰ "Search for jobs: Certified peer specialist," The Burrell Center, n.d., https://burrellcenter.wd5.myworkdayjobs.com/en-US/BBH/details/Certified-Peer-Specialist--Behavioral-Crisis-Center_R-5984?q=peer.

⁵¹ Interview with Kevin Huckshorn, EVP Northeast Region/Development Consulting at RI International, February 2022.

⁵² Interview with Lisa St. George, RI International, February 2022.

⁵³ Interview with Kevin Huckshorn, RI International, February 2022.

⁵⁴ Interview with Lisa St. George, RI International, February 2022.

⁵⁵ Michele Russell and Michael Rhinehart, "EMPACT mobile teams," n.d., https://www.azspc.org/uploads/8/5/7/7/85775014/michele_and_michael_-_hope_conference_training.pdf.

members of any team and it is important for all team members to understand and value the contribution that each makes to the work and support of individuals in crisis.⁵⁶ Ensuring peers are placed in environments and roles where their work is appreciated for its unique qualities is important to creating a successful team, and it positions them to help people in crisis.⁵⁷

Innovative approaches used by states to integrate peers in crisis systems

Many states are recognizing the importance of peers within mental health and SUD services. Effective growth of the peer support workforce will require them to implement multiple trainings to meet states’ certification standards. In addition, removing barriers and challenges to certification and employment can support the growth of peer supporters. Establishing policies that support peer services and peer specialist certification programs within the state are two steps many of them have taken to incorporate peers more effectively into crisis systems.

Approaches to increase peer involvement in crisis systems

Peers may face challenges being recognized as mental health and SUD service workers or overcoming justice-involved backgrounds to get certified as peer specialists. Screening peer specialists with justice-involved backgrounds may require case-by-case eligibility assessments to understand the circumstances of the person’s history, the reason for the arrest, and the length of time since the event(s). Several states have introduced legislation to remove barriers for peer involvement in crisis services and access their services. Below are a few examples of recent steps taken by states to eliminate these obstacles.

State	Peer initiatives
California SB-803 ⁵⁸	<ul style="list-style-type: none"> Expand the BH workforce by allowing the certification of peer support specialists⁵⁹ Develop a certification program for peer support specialists to provide services within California’s mental health and SUD treatment systems⁶⁰
Florida SB-282 ⁶¹	<ul style="list-style-type: none"> Increase the number of peer specialists through state training programs Improve background screening processes Extend the time that a prospective peer can seek an exemption to a disqualifying offense Eliminate certain charges that currently disqualify someone from working as a peer specialist

⁵⁶ Interview with Lisa St. George, RI International, February 2022.
⁵⁷ Substance Abuse and Mental Health Services Administration meeting convened by National Association of State Mental Health Program Directors, February 2022.
⁵⁸ “SB 803 signed into law: Win for peer support,” National Alliance on Mental Illness–California, accessed February 2022, <https://namica.org/blog/sb-803-signed-into-law-win-for-peer-support/>.
⁵⁹ “SB 803 signed into law,” National Alliance on Mental Illness–California, accessed February 2022.
⁶⁰ Ali Marzolf, “California pursues addition of peer support specialist services to list of Med-Cal-covered behavioral health services,” Aurrera Health, June 7, 2021, <https://www.aurrerahealth.com/california-pursues-addition-of-peer-support-specialist-services-to-list-of-med-cal-covered-behavioral-health-services/>.
⁶¹ Christine Jordan Sexton, “Out with COVID-19, Darryl Rousons peers move peer counseling bill through committee,” Florida Politics, January 19, 2022, <https://floridapolitics.com/archives/488057-out-with-covid-19-darryl-rousons-peers-move-peer-counseling-bill-through-committee/>.

State	Peer initiatives
Washington HB-1865 ⁶²	<ul style="list-style-type: none"> Establish a certified peer specialist credential to expand the BH workforce Allow people with commercial insurance to access peer specialists

Certification to support peer involvement in crisis systems

In many states, there are several certification programs that assist individuals with lived experience in learning about the role of peer supporters in crisis services. These trainings meet the required competencies identified in each state and SAMHSA’s Core Competencies for peer support. These certifications allow peers to work in BH and crisis services within the state and make their services eligible for reimbursement through Medicaid. Certification programs must be accessible to and affordable for peers and funders to support and increase their involvement in crisis systems.⁶³

RI International’s Certified Peer Recovery Support Specialist (CPRSS) training is a 76-hour program where students learn how to apply recovery skills and empower others in their own recovery journey. The CPRSS curriculum is state-certified in more than 17 states. It is also an approved training for the National Peer Support Certification, Veterans Administration curriculum, and has been customized to create trainings for Transition Age Youth and Family, as well as supporters and parents. RI International’s training also includes required training on the ethics and boundaries of peer support. Its crisis training for peer supporters covers all aspects of the peer supporters’ work as they enter the crisis continuum of care as service providers.⁶⁴

5. Integrating equity into crisis systems

In an ideal crisis care system, every individual and family with mental health and substance use issues has access to the least invasive services that are timely, effective, and achieve the best possible outcomes.⁶⁵ A comprehensive crisis system includes someone to talk to (24/7 crisis contact centers), someone to respond (24/7 MCT responses), and somewhere to go (short-term crisis stabilization services).⁶⁶ Building a comprehensive crisis system that serves all members of the community requires addressing the health inequities that exist within the system.

⁶² Hannah Furfaro and Esmay Jimenez, “Four ways lawmakers want to improve Washington’s mental health system,” *The Seattle Times*, January 20, 2022, <https://www.seattletimes.com/seattle-news/mental-health/four-ways-lawmakers-want-to-improve-washingtons-mental-health-system/>.

⁶³ Interview with Lisa St. George, RI International, February 2022.

⁶⁴ “Peer Support and Recovery Training,” RI International, accessed February 2022, <https://riinternational.com/peer-certification/>.

⁶⁵ Committee on Psychiatry and the Community for the Group for the Advancement of Psychiatry, “Roadmap to the ideal crisis system: essential elements, measurable standards, and best practices for behavioral health crisis response,” National Council for Behavioral Health, March 2021, https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031221_GAP_Crisis-Report_ExecutiveSummary-final.pdf?dof=375ateTbd56.

⁶⁶ “Field notes, Building a comprehensive and coordinated crisis system,” Field notes—Behavioral health, The Council of State Governments Justice Center, accessed February 2022, https://csgjusticecenter.org/wp-content/uploads/2021/04/Field-Notes_Comp-and-Coord-Crisis-System_508FINAL.pdf; “988: Reimagining crisis response,” National Alliance on Mental Illness, accessed February 2022, <https://www.nami.org/Advocacy/Crisis-Intervention/988-Reimagining-Crisis-Response#:~:text=800%2D950%2DNAMI&text=People%20in%20crisis%20deserve%20better>.

To build crisis services that serve all members of the community, state and territory health officials can:

- Partner with communities to build crisis systems
- Build crisis services that address the needs of specific populations
- **Additional resources:**
 - [SAMHSA National Guidelines for Behavioral Health Crisis Care](https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf) (https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf)
 - [The National Council Roadmap to the Ideal Crisis System](https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031221_GAP_Crisis-Report_ExecutiveSummary-final.pdf?daf=375ateTbd56) (https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031221_GAP_Crisis-Report_ExecutiveSummary-final.pdf?daf=375ateTbd56)

Role of community partnerships in building crisis systems

Community engagement is essential when designing crisis systems. Public health departments need to build deep, meaningful relationships with all groups that have specific needs and create opportunities to participate in decision-making for these populations. When the community is fully engaged, it:⁶⁷

- Increases awareness of available crisis services
- Ensures crisis services are relevant to the community's needs
- Builds trust between the community and the overall crisis system
- Facilitates a collaborative partnership in creating equitable policies, programs, and practices
- Establishes a feedback mechanism to improve upon services and community engagement

Building racial equity into crisis systems

Black, Indigenous, and people of color have been historically underserved, and are the most over-represented groups among individuals experiencing homelessness, mental health, and SUDs.⁶⁸ As the Local and Regional Government Alliance on Race and Equity (GARE) writes, “Too often, policies and programs are developed and implemented without thoughtful consideration of racial equity. When racial equity is not explicitly brought into operations and decision-making, racial inequities are likely to be perpetuated.”⁶⁹

⁶⁷ “HEDA: Conducting a health equity data analysis,” Version 2, Minnesota Department of Health, pg. 8, updated February 2018, <https://www.health.state.mn.us/data/mchs/genstats/heda/healthequitydataguideV2.0-final.pdf>.

⁶⁸ Morgan Medlock, “Centering racial equity: The role of sustained community partnership in behavioral health,” Webinar under contract HHSS283201200021/HHS28342003T, Substance Abuse and Mental Health Services Administration and the U.S. Department of Health and Human Services, <https://docplayer.net/224259887-Centering-racial-equity-the-role-of-sustained-community-partnership-in-behavioral-health-morgan-m-medlock-md-mdiv-mph-expert-consultant.html>.

⁶⁹ Local and Regional Government Alliance on Race & Equity (GARE), “Racial equity toolkit,” updated December 2016, accessed February 2022, https://racialequityalliance.org/wp-content/uploads/2015/10/GARE-Racial_Equity_Toolkit.pdf.

Steps states / territories can take to address disparities within crisis care systems include:⁷⁰

- Leveraging tools and frameworks to integrate health equity into crisis care systems
- Understanding the historical trauma and cultural divide that has created distrust in current systems
- Assessing crisis intervention outcomes and how they vary between groups within a region
- Looking at social and economic conditions that impact health and examine the policies and systems that influence those social and economic conditions

Example: Kentucky's Department for Behavioral Health, Developmental and Intellectual Disabilities (DBHDID) created and implemented a strategy to improve health equity throughout the state, using part of GARE's framework.⁷¹ This tool is both a product and a process, designed to integrate explicit consideration of racial equity in decisions that include policies, practices, programs, and budgets.⁷² Kentucky's entire Health and Human Services Cabinet is involved in reducing racial disparities to ensure efforts are impactful agency-wide.⁷³

- **Additional resources:**
 - [GARE](https://www.racialequityalliance.org/tools-resources/) Racial equity tools (https://www.racialequityalliance.org/tools-resources/)
 - [Minnesota Department of Health](https://www.health.state.mn.us/data/mchs/genstats/heda/healthequitydataguideV2.0-final.pdf) Conducting a Health Equity Data Analysis (https://www.health.state.mn.us/data/mchs/genstats/heda/healthequitydataguideV2.0-final.pdf)

Building crisis services for specific populations

Each group within a community has its own unique considerations that need to be considered when designing crisis systems. Services must be accessible to each group, reliable, and trusted so group members will use these critical services. Below are examples of services designed to meet the needs of children, adolescents, and families, LGBTQ+ youth, members of tribes, individuals who are deaf or hard of hearing, and individuals with intellectual and/or developmental disabilities (IDD).

Case study: Building a crisis system around children, youth, and families⁷⁴

Children and adolescents are physically, mentally, and emotionally different than adults, and therefore have different needs. These differences must be taken into consideration when designing crisis services for children and youth. Without proper intervention, children and youth may be at risk of hospitalization or removal from their home. Proactive and compassionate services that focus on de-escalation, rather than transport to a hospital or

⁷⁰ "HEDA: Conducting a health equity data analysis," Minnesota Department of Health, pg. 6, updated February 2018.

⁷¹ "Kentucky's Innovative Framework to Systematize a Structural Process around Racial Equity with the National Association of State Mental Health Program Directors," March 2022.

⁷² Local and Regional Government Alliance on Race & Equity, "Racial equity toolkit," updated December 2016.

⁷³ "Kentucky's Innovative Framework to Systematize a Structural Process," March 2022.

⁷⁴ Casey Family Programs, "What is New Jersey's mobile response and stabilization services intervention?," pg. 2, updated May 2018, https://caseyfamilypro-wpengine.netdna-ssl.com/media/SF_New-Jersey-MRSS.pdf.

detention facility, help children, youth, and their families address behavioral crises, lead to better health outcomes, and improve stability within homes, schools, and communities.⁷⁵

New Jersey's Mobile Response and Stabilization Services (MRSS) was developed to provide intervention and support for "children experiencing escalating emotional symptoms, behaviors, or traumatic circumstances that have impacted their ability to function within their family, living situation, school, or community."

With MRSS, a BH worker is available to any family anywhere in the state of New Jersey at any time (24/7/365). If there is a crisis, a MRSS worker is available within an hour to help de-escalate, assess, and develop a plan together with the child and family. The agency follows a four-pronged approach:

- On-site intervention for immediate de-escalation of presenting emotional symptoms and behaviors
- Assessment, planning, skill building, psycho-education, and resources to stabilize the presenting emotional symptoms and behaviors
- Assistance to the child and family in returning to baseline or routine functioning
- Providing prevention strategies and resources to cope with presenting emotional symptoms and behaviors and create a plan to avoid future crises

MRSS services are available to children and their families for 72 hours and up to eight weeks following the request for help. Services vary according to the child and family's needs, but may include:

- In-home counseling
- Behavioral assistance
- Caregiver therapeutic support
- Skill-building
- Medication management
- Coordination and development of informal and natural support systems, such as faith-based organizations, mentors, and peer support
- Coordination of specialized services to address the needs of children with co-occurring developmental disabilities and substance use

MRSS is supported through the following sources of funding:

- Medicaid Rehabilitation Option, which allows for reimbursement under Early Periodic Screening Diagnostic and Testing
- State funding for children who are not eligible for the state's public health care plan and do not have private insurance
- Third-party liability coordination for families that may have insurance coverage
- Wrap / Flex funds to support services not covered by Medicaid

Since its inception in 2004, MRSS has consistently maintained 94 percent of children in their living situation at the time of service and families have reported high satisfaction with services, with a 250 percent increase in families accessing MRSS.⁷⁶

⁷⁵ National Association of State Mental Health Program Directors, "Assessment #9: Improving the child and adolescent crisis system: Shifting from a 911 to a 988 paradigm," August 2020, <https://www.nasmhpd.org/sites/default/files/2020paper9.pdf>.

⁷⁶ "The role of mobile response in transforming children's behavioral health: The New Jersey experience," New Jersey Department of Children and Families, 2017, accessed February 2022, <https://www.macmhb.org/sites/default/files/attachments/files/Transforming%20New%20Jersey%E2%80%99s%20Children%E2%80%99s%20Behavioral%20Health%20The%20Role%20of%20Mobile%20Response%20PowerPoint.pdf>.

Training to improve crisis services for LGBTQ+ youth

Suicide is the second leading cause of death for children, adolescents, and young adults, and certain communities, including LGBTQ+ people, are at heightened risk.⁷⁷ For example, LGB youth seriously consider attempting suicide at almost three times the rate of heterosexual youth.⁷⁸ In order to increase Lifeline crisis counselors' competency in serving these at-risk youth, the Lifeline Standards, Training, and Practices Committee has begun collaborating with the Trevor Project, a nonprofit organization focused on suicide prevention efforts among LGBTQ+ youth. The Trevor Project estimates that more than 1.8 million LGBTQ+ youth between the ages of 13 and 24 in the U.S. seriously consider suicide each year and could benefit from their services.⁷⁹ It also estimates that at least one LGBTQ+ person (age 13-24) attempts suicide every 45 seconds.⁸⁰

The Trevor Project operates the Trevor Lifeline, a national 24/7 crisis intervention and suicide prevention lifeline for LGBTQ+ young people under age 25. SAMHSA, the Lifeline, and the Trevor Project aim to align best practices, noting where practices differ due to cultural needs (and evidence / a rationale exists that underpins the distinctions). Once practices are aligned and differences understood, the work before the Lifeline becomes active in July 2022 would include:

- Updating network counselor training materials and culturally competent and responsive resources for serving LGBTQ+ youth
- Adapting Lifeline network center membership processes to incorporate organizations providing specialized services for high-risk populations
- Designing and implementing seamless Lifeline-to-Trevor Project transfers for LGBTQ+ youth contacting the Lifeline through Integrated Voice Response (IVR) or warm transfer for those who are not at imminent risk and who consent to being connected with the Trevor Lifeline
- Organizing and planning webinars for the Lifeline network to review basic practices, including IVR and warm transfers

Partnering with tribes to increase access to crisis services for tribal members

Given the status of tribes as sovereign nations, there can be limitations regarding access to medical care and crisis services for tribal members within a state. For example, if authorization is required for state rescue units to go onto tribal reservations, this can be a barrier to delivering care. In addition, tribal members whose reservations span multiple states can face challenges covering the costs of medical services in one state versus another. Engagement with tribes by states should occur on an individual basis when developing crisis services to ensure timely, quality, and affordable care for tribal members, which can help to address these challenges.⁸¹

Tribes have the right to exclude persons from tribal lands. Although most tribes do not have closed reservations, it is important for states and counties to consult with tribes to clarify under what scenarios a formal agreement is required for state or county rescue units to go

⁷⁷ "Preventing suicide," Centers for Disease Control, accessed February 2022, <https://www.cdc.gov/suicide/pdf/preventing-suicide-factsheet-2021-508.pdf>.

⁷⁸ "Preventing suicide," Centers for Disease Control, accessed February 2022.

⁷⁹ The Trevor Project, Trevor News, "National estimate of LGBTQ youth seriously considering suicide," June 27, 2019, accessed February 2022, <https://www.thetrevorproject.org/blog/national-estimate-of-lgbtq-youth-seriously-considering-suicide/>.

⁸⁰ "Estimate of how often LGBTQ youth attempt suicide in the U.S.," The Trevor Project, March 11, 2021, accessed February 2022, <https://www.thetrevorproject.org/research-briefs/estimate-of-how-often-lgbtq-youth-attempt-suicide-in-the-u-s/>.

⁸¹ Interview with Pamela End of Horn, National Suicide Prevention Consultant at U.S. Department of Health and Human Services, February 2022.

Tribes have the right to exclude persons from tribal lands. Although most tribes do not have closed reservations, it is important for states and counties to consult with tribes to clarify under what scenarios a formal agreement is required for state or county rescue units to go onto tribal lands. There may be some instances, such as voluntary requests, where rescue units would not need specific permission to enter reservations to provide services to tribal members. However, if there is law enforcement involvement or the response is for an involuntary commitment, tribal or Bureau of Indian Affairs (BIA) officers with a tribal court order may be required.⁸²

Financial coverage for crisis services is another consideration that is based on the tribe, as well as the type and location of services provided (e.g., mobile crisis on-scene, crisis receiving facility). States and crisis services providers can consult with the local Indian Health Services (IHS) facilities to outline the best approach to providing crisis services to tribal members across all tribes within their jurisdictions. In general, all IHS beneficiaries are eligible for care at any IHS facility. However, if there is an expectation that local IHS will pay for care at non-IHS facilities, then state or county rescue units and responders need to understand IHS' [Purchased / Referred Care \(PRC\)](https://www.ihs.gov/prc/) process (<https://www.ihs.gov/prc/>).⁸³

To establish best practices for administering crisis services and care to tribal members, states and counties can consider:⁸⁴

- Initiating consultation with each tribe within the state
- Consulting with tribes regarding services and jurisdiction considerations
- Consulting with BIA on jurisdictional matters
- Partnering with the local IHS facilities to initiate services

Building crisis services for individuals who are deaf or hard of hearing

The BH crises experienced by those who are deaf or hard of hearing often go unseen because of society's bias towards hearing. During critical interactions, such as crisis intervention and issues of life and death, comprehension is essential and is best negotiated in a person's strongest language. For many deaf people, this language is ASL.⁸⁵

Having well-trained ASL contact operators and the video technology to support callers who are deaf or hard of hearing helps foster trust between the provider and individual in crisis. A well trained ASL-fluent counselor will know that some deaf callers have grown up in an impoverished language environment, which is a unique experience of people who are deaf. The person calling might have gaps in vocabulary or grammar, resulting in informational deficits that can appear to look like psychosis.⁸⁶ Through direct communication using video technology, the ASL counselor can assess the complex interplay of language dysfluency and clinical symptomology, something that could be lost when using an interpreter or relay services.⁸⁷

⁸² Interview with Pamela End of Horn, February 2022.

⁸³ Interview with Pamela End of Horn, February 2022.

⁸⁴ Interview with Pamela End of Horn, February 2022.

⁸⁵ Stephanie Hepburn, "988 and deaf services," #CrisisTalk, February 22, 2022, <https://talk.crisisnow.com/988-and-deaf-services/>.

⁸⁶ Stephanie Hepburn, "988 and deaf services," February 22, 2022.

⁸⁷ National Association of State Mental Health Program Directors, "NASMHPD Recommendations for Effective Communication Planning and Response with Deaf Communities for 988," accessed February 2022, https://www.nasmhpd.org/sites/default/files/NASMHPD_Recommendations_on_988_and_Deaf_Crisis_Services.pdf.

The National Association of State Mental Health Program Directors (NASMHPD) recommends that one national call center be established for people who are deaf and hard of hearing. States / territories can help contact centers support this underserved group by establishing:⁸⁸

- The resources necessary to provide crisis contact services to individuals who are deaf and hard of hearing (e.g., ASL-fluent counselors, video technology)
- A mechanism to provide follow-up calls for deaf and hard-of-hearing callers
- A state coordinator of deaf mental health care to provide resources to local callers and updated local resources to the national 988 call center for people who are deaf and hard of hearing
- Peer support programming and certification opportunities for deaf and hard-of-hearing communities

Building crisis services for individuals with intellectual and/or developmental disabilities (IDD)

People with IDD may only represent a small fraction of overall psychiatric and substance use emergencies. However, individuals with IDD may not be able to communicate their needs, and therefore service workers responding to an IDD crisis must have the proper training to assess and de-escalate the episode without inciting harm.⁸⁹

With the transition to 988, states / territories have the opportunity to build and expand access to crisis services capable of better serving individuals with IDD. These could include:⁹⁰

- Virtual co-location / access to IDD specialists for crisis contact centers, MCTs, and crisis receiving and stabilizing facilities
- Establish “no-wrong-door” policies for those with IDD experiencing a BH crisis in need of facility-based care
- Amend Medicaid state plans that may exclude the provision of crisis services to those with a primary diagnosis of IDD

In addition, states / territories can establish partnerships with state IDD agencies, centers for independent living, and other developmental disabilities advocacy organizations to raise awareness about IDD and connect people with IDD to crisis care and other resources they need.⁹¹

⁸⁸ National Association of State Mental Health Program Directors, “NASMHPD Recommendations for Effective Communication,” accessed February 2022.

⁸⁹ Stephanie Hepburn, “Mary Sowers on getting rid of policy relics and ensuring 988 works for people with IDD,” #CrisisTalk, March 1, 2022, <https://talk.crisisnow.com/mary-sowers-on-getting-rid-of-policy-relics-and-ensuring-988-works-for-people-with-idd/>.

⁹⁰ Stephanie Hepburn, “Mary Sowers on getting rid of policy relics,” March 1, 2022.

⁹¹ Stephanie Hepburn, “Mary Sowers on getting rid of policy relics,” March 1, 2022.

6. Financial sustainability

The importance of diverse and sustainable funding sources to support 988 and integrated crisis care

Approaches to fund BH crisis services vary widely from state to state.⁹² A diversified approach that encompasses a variety of sustainable financing mechanisms is essential to ensure the BH crisis system is equipped to address the needs of all individuals.⁹³

Those states that currently lack adequate long-term funding for 988 and the broader crisis system can conduct a full inventory of potential additional funding sources to explore which funding sources are most appropriate for their needs. Major funding sources may include:

- Federal grants
- American Rescue Plan Act of 2021 (ARPA) funding
- Medicaid
- Telecommunications fees

Federal grant funding for behavioral health crisis services

Grant	Eligibility	Available funding	Uses	Relevant populations
SAMHSA Community Mental Health Services Block Grant (MHBG) ⁹⁴	<ul style="list-style-type: none"> • Noncompetitive, formula grant • Available to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, and six Pacific jurisdictions⁹⁵ 	FY 2022 proposed budget request is \$1.6 billion ⁹⁶	<ul style="list-style-type: none"> • Provides comprehensive, mental health services to adults with serious mental illnesses (SMIs) and to children with serious emotional disturbances (SEDs) • Monitors progress in implementing a comprehensive, community-based mental health system⁹⁷ 	<ul style="list-style-type: none"> • Adults with SMIs • Children with SEDs

⁹² "National Guidelines for Behavioral Health Care," pg. 36.
⁹³ Substance Abuse and Mental Health Services Administration, "Crisis services: Effectiveness, cost effectiveness, and funding strategies," HHS Publication No. (SMA)-14-4848, pg. 17, 2014, https://www.nasmhpd.org/sites/default/files/SAMSHA%20Publication%20on%20Effectiveness%20%26%20Cost-Effectiveness%20of%2C%20and%20Funding%20Strategies%20for%2C%20Crisis%20Services%206-5-14_8.pdf.
⁹⁴ "Community mental health services block grant," Substance Abuse and Mental Health Services Administration, April 16, 2020, accessed February 2022, <https://www.samhsa.gov/grants/block-grants/mhbg>.
⁹⁵ Interview with Tison Thomas, U.S. Department of Health and Human Services, January 2022.
⁹⁶ Health Resources and Services Administration in the U.S. Department of Health and Human Services, "FY 2022 Justification of estimates for appropriations committees," pg. 3, accessed February 2022, <https://www.hrsa.gov/sites/default/files/hrsa/about/budget/budget-justification-fy2022.pdf>.
⁹⁷ Interview with Tison Thomas, January 2022.

Grant	Eligibility	Available funding	Uses	Relevant populations
SAMHSA Mental Health Block Grant set-aside	<ul style="list-style-type: none"> Available to all states and territories awarded the MHBG⁹⁸ 	5 percent of the MHBG allocation ⁹⁹	<ul style="list-style-type: none"> Supports 24/7 mobile crisis units and short-term residential crisis stabilization beds Delivers evidence-based services to individuals with suicide risk Helps regional / state-wide crisis call centers coordinate real time¹⁰⁰ 	
SAMHSA Substance Abuse and Treatment Block Grant (SABG) ¹⁰¹	<ul style="list-style-type: none"> Noncompetitive formula grant Available to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, six Pacific jurisdictions, and one tribal entity to prevent and treat substance abuse¹⁰² 	FY 2022 proposed budget request is \$3.5 billion (with a 20 percent set-aside for prevention programs) ¹⁰³	<ul style="list-style-type: none"> Helps plan, implement, and evaluate activities that prevent and treat substance abuse¹⁰⁴ Supplemented by Strategic Alliance Business Group (SABG), COVID-19 and American Rescue Plan (ARP) supplemental funding. Additional priority activities to enhance crisis care include the use of peer coaches in hospital emergency departments and the operation of “crisis phone lines” or “warm lines” by treatment providers¹⁰⁵ 	<p>Primary target audiences include:¹⁰⁶</p> <ul style="list-style-type: none"> Pregnant women and women with dependent children Intravenous drug users Tuberculosis services Early intervention services for HIV / AIDS Primary prevention service <p>Additional target populations include:¹⁰⁷</p> <ul style="list-style-type: none"> Persons involved in the justice system Persons involved in the child welfare system

⁹⁸ Interview with Tison Thomas, January 2022.

⁹⁹ Interview with Tison Thomas, January 2022.

¹⁰⁰ Substance Abuse and Mental Health Services Administration, “Application for the mental health block grant and substance abuse block grant: FY 2020-2021 applications guidance and instructions,” n.d., accessed February 2022, pg. 1, https://www.samhsa.gov/sites/default/files/grants/oppi_fy2020-2021_bgsupportingstatement_508.pdf.

¹⁰¹ “Substance abuse prevention and treatment block grant,” accessed February 2022.

¹⁰² “Substance abuse prevention and treatment block grant,” February 2022.

¹⁰³ Health Resources and Services Administration, “FY 2022 Justification of estimates,” pg. 2, accessed February 2022.

¹⁰⁴ “Substance abuse prevention and treatment block grant,” February 2022.

¹⁰⁵ Interview with Spencer Clark, Public Health Advisor in the Division of State and Community Assistance in Substance Abuse and Mental Health Services Administration, January 2022.

¹⁰⁶ “Substance abuse prevention and treatment block grant,” February 2022.

¹⁰⁷ Interview with Spencer Clark, January 2022.

Grant	Eligibility	Available funding	Uses	Relevant populations
			<ul style="list-style-type: none"> • Provides increased access, including same- / next-day appointments for those in need of SUD treatment services • Improves information technology infrastructure for providers in rural and frontier areas 	<ul style="list-style-type: none"> • Black, Indigenous, and People of Color (BIPOC) • LGBTQ+ individuals • Rural populations • Youth who are using or are at risk for using alcohol and tobacco
SAMHSA State Opioid Response Grant (SOR) ¹⁰⁸	<ul style="list-style-type: none"> • Formula-based grant • Available to Single State Agencies (SSAs) and territories¹⁰⁹ 	FY 2022 proposed budget request is \$2.3 billion ¹¹⁰	<ul style="list-style-type: none"> • Increases access to medications for opioid use disorder (MOUD) • Reduces unmet treatment needs • Reduces opioid overdose-related deaths through prevention, treatment, and recovery activities¹¹¹ • Has crisis services that have been implemented through the SOR program that include:¹¹² <ul style="list-style-type: none"> ○ 24-hour crisis lines ○ Mobile crisis response ○ Peer support ○ Crisis stabilization units ○ Crisis residential services ○ Training on crisis services 	Target populations and intended uses of SOR funds are presented by applicants ¹¹³

¹⁰⁸ “State opioid response grants,” Substance Abuse and Mental Health Services Administration, accessed February 2022, <https://www.samhsa.gov/grants/grant-announcements/ti-20-012>.

¹⁰⁹ “State opioid response grants,” accessed February 2022.

¹¹⁰ Substance Abuse and Mental Health Services Administration, “FY 2022 Justification of estimates for appropriations committees,” pg. 2, accessed February 2022, <https://www.samhsa.gov/sites/default/files/samhsa-fy-2022-cj.pdf>.

¹¹¹ Interview with Jenifer Gianello, January 2022.

¹¹² Interview with Jenifer Gianello, January 2022.

¹¹³ Substance Abuse and Mental Health Services Administration, “State opioid response grants, Funding opportunity announcement No. T1-20-012, pgs. 18-19, accessed February 2022, <https://www.samhsa.gov/sites/default/files/grants/pdf/fy-2020-sor-foa.pdf>.

Grant	Eligibility	Available funding	Uses	Relevant populations
SAMHSA Tribal Opioid Response Grants (TOR) ¹¹⁴	<ul style="list-style-type: none"> • Non-competitive grant based on population size¹¹⁵ • Federally recognized American Indian or Alaska Native tribe or tribal organization¹¹⁶ 	FY 2021 \$37.6 million ¹¹⁷	<ul style="list-style-type: none"> • Increases access to culturally appropriate evidence-based treatment • Develops and provides prevention and treatment services • Implements peer support, recovery coaches, spiritual support, and recovery housing services • Provides treatment coverage for justice-involved patients re-entering communities¹¹⁸ 	Members of federally recognized American Indian or Alaska Native tribes
Tribal Behavioral Health Grant Program (Native Connections) ¹¹⁹	<ul style="list-style-type: none"> • Federally recognized American Indian or Alaska Native tribe or tribal organization¹²⁰ 	FY 2021 \$7.2 million ¹²¹	<ul style="list-style-type: none"> • Develops and implements mental health, trauma, suicide, and substance abuse prevention programs serving youth:¹²² <ul style="list-style-type: none"> ○ Develop / revise protocols to ensure at-risk youth receive follow-up services ○ Implement mental health awareness training 	Youth (24 and under) of federally recognized American Indian or Alaska Native tribes who are at risk of suicide and/or substance use ¹²³

¹¹⁴ Substance Abuse and Mental Health Services Administration, “FY 2021 tribal opioid response grants, Funding opportunity announcement No. T1-21-007,” accessed February 2022, <https://www.samhsa.gov/sites/default/files/grants/pdf/fy-2021-tor-foa.pdf>.<https://www.samhsa.gov/grants/grant-announcements/ti-21-007>.

¹¹⁵ Substance Abuse and Mental Health Services Administration, “FY 2021 tribal opioid response grants,” accessed February 2022.

¹¹⁶ Substance Abuse and Mental Health Services Administration, “FY 2021 tribal opioid response grants,” accessed February 2022.

¹¹⁷ Substance Abuse and Mental Health Services Administration, “FY 2021 tribal opioid response grants,” accessed February 2022.

¹¹⁸ Substance Abuse and Mental Health Services Administration, “FY 2021 tribal opioid response grants,” accessed February 2022.

¹¹⁹ “Tribal behavioral health grant program,” Substance Abuse and Mental Health Services Administration, accessed February 2022, <https://www.samhsa.gov/grants/grant-announcements/SM-21-011>.

¹²⁰ “Tribal behavioral health grant program,” accessed February 2022.

¹²¹ “Tribal behavioral health grant program,” accessed February 2022.

¹²² Substance Abuse and Mental Health Services Administration, “Tribal behavioral health grant program, Funding opportunity announcement No. SM-21-011, pgs. 18-19, accessed February 2022, <https://www.samhsa.gov/sites/default/files/grants/pdf/fy-2021-tbh-foa.pdf>.

¹²³ “Tribal behavioral health grant program, accessed February 2022.

Grant	Eligibility	Available funding	Uses	Relevant populations
			<ul style="list-style-type: none"> ○ Implement substance misuse prevention strategies 	
SAMHSA Transformation Transfer Initiative (TTI) ¹²⁴	<ul style="list-style-type: none"> • Competitive-based grant • Available to all 50 states, the District of Columbia, and Territories¹²⁵ 	In FY 2022, 36 TTI grants of \$250,000 were awarded ¹²⁶	<ul style="list-style-type: none"> • Implements and expands 988 crisis services to include:¹²⁷ <ul style="list-style-type: none"> ○ Increasing BH providers and expanding services ○ Integrating specialists into mobile crisis to support LGBTQ+ needs ○ Expanding wraparound crisis services for children and youth 	FY 2022 target audiences include: ¹²⁸ <ul style="list-style-type: none"> • American Indian / Alaska Native (AI / AN) communities • LGBTQ+ • Children and adolescents

- **Additional resources:**

- [SAMHSA](https://www.samhsa.gov/grants/grant-announcements-2022) FY 2022 Grant Announcements and Awards (https://www.samhsa.gov/grants/grant-announcements-2022)

¹²⁴ "Transformation transfer initiative," National Association of State Mental Health Program Directors, accessed February 2022, <https://www.nasmhpd.org/transformation-transfer-initiative->.

¹²⁵ "Transformation transfer initiative," National Association of State Mental Health Program Directors, accessed February 2022.

¹²⁶ National Association of State Mental Health Program Directors, "TTI 2022 memorandum," September 2021, https://www.nasmhpd.org/sites/default/files/TTI2022%20Memorandum%20Sept_2021.pdf.

¹²⁷ National Association of State Mental Health Program Directors, "Transformation transfer initiative application," n.d., accessed February 2022, <https://www.nasmhpd.org/sites/default/files/FY22%20TTI%20Application.pdf>.

¹²⁸ National Association of State Mental Health Program Directors, "TTI 2022 memorandum," September 2021.

American Rescue Plan Act of 2021 funding for mobile crisis and crisis line services

ARPA authorizes states to provide community-based mobile crisis intervention services for a period of up to five years.¹²⁹ Funding is available for implementing and administering these services.¹³⁰ To be eligible for funding, the services must be:¹³¹

- Provided to individuals who are Medicaid-eligible through the state plan or waiver and experiencing a mental health or SUD crisis outside of a hospital or other facility setting
- Delivered by a multi-disciplinary team that includes at least one BH care professional and another with expertise in BH crisis intervention (e.g., nurses, social workers, trained peers)
- Comprised of screening and assessment, stabilization and de-escalation, and coordination with and referrals to health, social, and other services and supports as needed
- Available 24 hours a day, every day of the year

In addition, funding may be available to cover the administrative and IT costs associated with establishing and supporting mobile crisis intervention services, as well as call centers and other crisis stabilization services.¹³² These costs include, but are not limited to:¹³³

- Systems in support of establishing and/or improving crisis call centers
 - Systems integration activities in support of the 988 activities
 - Providing cell phones or iPads to state-staffed MCTs to facilitate telehealth services
 - Developing and implementing applications to facilitate communication between crisis call centers, mobile crisis providers, and supervisory clinicians with MCT staff
 - Implementing text and chat technologies and other technologies for individuals with disabilities
- **Additional resources:**
 - [CMS](https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf) Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based Mobile Crisis Intervention Services (https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf)
 - [TAC](https://www.tacinc.org/resource/state-planning-guide-for-medicaid-financed-mobile-crisis-response/) MCTs: A State Planning Guide for Medicaid-Financed Crisis Response Services (https://www.tacinc.org/resource/state-planning-guide-for-medicaid-financed-mobile-crisis-response/)

¹²⁹ Centers for Medicare & Medicaid Services, “Re: Medicaid guidance on the scope of and payments for qualifying community-based mobile crisis intervention services,” pg. 1, December 28, 2021, <https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf>.

¹³⁰ “State planning grants for qualifying community-based mobile crisis intervention services,” Centers for Medicare & Medicaid Services, American Rescue Plan of 2021: Section 9813, accessed February 2022, <https://www.medicaid.gov/medicaid/benefits/behavioral-health-services/state-planning-grants-for-qualifying-community-based-mobile-crisis-intervention-services/index.htm>.

¹³¹ Centers for Medicare & Medicaid Services, “Re: Medicaid guidance on the scope of and payments for,” pgs. 6-8, December 28, 2021.

¹³² Centers for Medicare & Medicaid Services, “Re: Medicaid guidance on the scope of and payments for,” pg. 11, December 28, 2021.

¹³³ Centers for Medicare & Medicaid Services, “Re: Medicaid guidance on the scope of and payments for,” pg. 12, December 28, 2021.

Medicaid funding for behavioral health crisis services

Medicaid coverage underpins the ability of states to advance access to mental health and substance use services, including crisis services, for people with low incomes. Expanding crisis services through Medicaid allows states to reserve discretionary funds (e.g., MHBG, SABG, other federal grants) to cover costs not covered by the state plan.¹³⁴

As outlined by Wachino et al. (2021), there are several potential avenues (“building blocks”) states and territories can explore to determine how to use their Medicaid funding for crisis services.¹³⁵ Examples of states that have used each potential Medicaid lever have been captured from other sources as referenced below.

MEDICAID BUILDING BLOCKS TO ADVANCE CRISIS SERVICES ¹³⁶		
Authority	Key Elements	State Examples
Building Block 1: Expanding benefits to cover crisis services		
Rehabilitative services option	The rehabilitative services option can cover diagnostic, screening, preventive, and rehabilitative services to address physical or mental conditions and restore individual functioning. It is commonly used by states to cover a range of community mental health services, including crisis services	Louisiana uses the rehabilitative services option to cover crisis intervention services, referrals to alternative mental health services, short-term intervention, and follow up services ¹³⁷
Clinic option	The clinic option covers services that are furnished on-site at a clinic or off-site to people who are homeless. It is often used to provide outpatient BH services and can be used to cover crisis services	Maine and Wisconsin authorize crisis services under the clinic option ¹³⁸
Services of other licensed practitioners	States can cover remedial and medical services provided by licensed practitioners, such as paramedics and addiction counselors	
Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)	Medicaid’s comprehensive pediatric benefit, EPSDT, requires states to cover medically necessary services to children. Many states authorize services for children under optional benefits authorities, but EPSDT ensures access to needed services, including crisis services, for children even if a state has not elected optional benefits	Massachusetts covers mobile crisis services for children as covered rehabilitative services in a state plan amendment under EPSDT ¹³⁹

¹³⁴ Interview with Vikki Wachino, Principal at Viaduct LLC, January 2022.
¹³⁵ Vicki Wachino and Natasha Camhi, “Building blocks: How Medicaid can advance mental health and substance use crisis response,” Well Being Trust, pg. 1, May 18, 2021, <https://wellbeingtrust.org/news/how-medicaid-can-advance-mental-health-and-substance-use-crisis-response/>.
¹³⁶ Vicki Wachino, “Building blocks: How Medicaid,” pg. 10, May 18, 2021.
¹³⁷ Centers for Medicare & Medicaid Services, “Louisiana state plan amendment approval letter (SPA LA #15-0030), May 9, 2016, <https://dh.la.gov/assets/medicaid/StatePlan/Amend2015/15-0030CMSApproval.pdf>.
¹³⁸ Substance Abuse and Mental Health Services Administration, “Crisis services: Effectiveness, cost effectiveness,” 2014.
¹³⁹ Massachusetts State Plan Amendment (TN #08-004), effective April 1, 2009, accessed February 2022.

Authority	Key Elements	State Examples
Building Block 2: Increasing access to home and community-based services (HCBS)		
1915(c) HCBS waivers	HCBS provide some Medicaid beneficiaries with the option to receive care at home or in the community. States can target specific geographies and populations. HCBS authorized 1915(c) waivers serve seniors and people with physical and developmental disabilities	
1915(i) HCBS state plan option	Under 1915(i) authority, states can cover HCBS for specific populations of people, such as people with BH conditions	Maryland’s 1915(i) program serves seniors and people with disabilities and includes 24/7 mobile crisis services ¹⁴⁰
Building Block 3: Using managed care to organize delivery of services		
“In lieu of” services	“In lieu of” services are alternative services and settings that are cost effective, clinically appropriate substitutes for those that are explicitly authorized under a state Medicaid plan. States and managed care plans can use this authority to cover some crisis services	In Florida and Oregon, some managed care organizations are providing crisis services as “in lieu of” services ¹⁴¹
1915(a) waivers	Section 1915(a) waivers enable states to create managed care programs that operate on a regional basis and establish a specific provider network. These managed care programs can focus specifically on behavioral health services or provide a broader set of services.	Wisconsin’s ‘Wraparound Milwaukee’ program serves youth with behavioral, emotional, and mental health needs, and has children’s MCTs which can provide crisis intervention and case management to families ¹⁴²
1915(b) waivers	Through section 1915(b) waivers, states can implement statewide Medicaid managed care systems and establish a specific provider network. These managed care programs can focus specifically on BH services or provide a broader set of services	Michigan used a 1915(b) managed care waiver to help cover services that include crisis response. Residential and ambulatory services, MCTs, and crisis call lines are covered ¹⁴³

¹⁴⁰ Maryland Department of Health, “1915(i) State plan home and community-based services administration and operation,” 2014, https://health.maryland.gov/bhd/Documents/1915_i_ApprovedSPA.pdf.

¹⁴¹ Agency for Health Care Administration, “Florida Core Contract Provisions,” p. 78, September 1, 2021, https://ahca.myflorida.com/medicaid/statewide_mc/pdf/Contracts/2021-10-01/Attachment_II_Core_Contract_Provisions_2021-10-01.pdf; PacificSource Community Solutions, “PacificSource coordinated care organizations (CCO) member handbook,” January 2021, <https://communitysolutions.pacificsource.com/PDF/Handbook/MarionPolk>; “Alternative payment and advanced care model,” Oregon Primary Care Association, accessed February 2022, <https://www.orpca.org/initiatives/alternative-care-model>.

¹⁴² In addition to 1915(a), Wisconsin reports that it covers crisis services through Medicaid’s clinic and rehabilitative services options, as well as a mix of local, state, and federal grants. Substance Abuse and Mental Health Services Administration, “Crisis services: Effectiveness, cost effectiveness,” pg. 21, 2014; “Wraparound Milwaukee,” Wisconsin Department of Health Services, last updated October 7, 2020, <https://www.dhs.wisconsin.gov/medicaid/wam.htm#:~:text=Wraparound%20Milwaukee%20is%20a%20program,Milwaukee%20County%20Behavioral%20Health%20Division%20>.

¹⁴³ Michigan reported in 2014 that the majority of Michigan’s crisis services—including residential and emergency crisis services—were provided through a 1915(b) waiver, as well as other authorities, including a 1915(c) waiver. Substance Abuse and Mental Health Services Administration, “Crisis services: Effectiveness, cost effectiveness,” pg. 37, 2014; Gary Smith et al., “Using Medicaid to support working-age adults with serious mental illnesses in the community: A Handbook,” Office of the Assistant Secretary for Planning and Evaluation, Chapter 4 and Appendix C, January 23, 2005, <https://aspe.hhs.gov/report/using-medicaid-support-working-age-adults-serious-mental-illnesses-community-handbook>.

Authority	Key Elements	State Examples
Building Block 4: Strengthening service delivery through 1115 demonstration waivers		
Section 1115 SMI / SED service delivery waivers	States can strengthen service delivery for people with SMIs or SEDs through 1115 demonstrations that prioritize expanding access to crisis services as part of a broader continuum of care	Washington DC increased the availability of call centers, mobile crisis units, outpatient services, and inpatient services in its 1115 demonstration ¹⁴⁴
Building Block 5: Financing crisis-related administrative spending		
Administrative matching	Federal administrative matching funds can support state spending on the administration of crisis service programs, including crisis call lines	

The 988 transition creates a significant opportunity for state agencies that oversee mental health and substance use services to collaborate with state Medicaid agencies. In engaging with Medicaid agencies, leaders of mental health and substance use agencies can provide:

- An introduction to 988 and its importance for the Medicaid population
- An inventory of the crisis services offered in the state and the benefits of comprehensive crisis services, particularly for the Medicaid population
- A business case for funding of crisis services

Mental health and substance use agencies and Medicaid agencies will need to work together to determine optimal funding pathways for components of the crisis system.

Medicaid funding for tribes

Through the Federal Medical Assistance Percentage (FMAP) for Long-term Services and Supports (LTSS) program, eligible services provided to Medicaid-eligible American Indian / Alaska Native (AI / AN) patients in Indian Health Services (IHS) or tribal facilities can be reimbursed at 100 percent FMAP.

Since CMS reimburses these expenses fully, eligible services provided to Medicaid-eligible AI / AN patients in IHS or tribal facilities can be delivered at no cost to the state. With these savings, states can often afford to reimburse tribes for tribally-provided Medicaid services at an enhanced rate that is higher than 100%. Receiving an enhanced reimbursement rate from states provides tribes with more resources to support delivery of LTSS.

¹⁴⁴ Centers for Medicare & Medicaid Services, "Washington, DC's 1115 demonstration approval letter," December 19, 2019, <https://www.medicare.gov/medicaid/section-1115-demonstrations/downloads/dc-behavioral-health-transformation-initial-appvl-12192020.pdf>.

To be eligible for 100 percent FMAP, tribal programs must meet the following requirements:¹⁴⁵

- LTSS must be explicitly included in a tribe's P.L. 638 contract or compact with IHS
- The tribal health department must either provide or oversee LTSS. States can either:
 - Have the state tribal health department set up a funding agreement with the tribal aging program or department to provide LTSS
 - Move the state LTSS program under the tribal health department
- The health department must bill the state Medicaid office for LTSS

- **Additional resources:**
 - [CMS](https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/100-percent-fmap-educate-your-state#:~:text=CMS%20reimburses%20each%20state%20for,typically%20have%20a%20higher%20FMAP) FMAP for LTSS (https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/100-percent-fmap-educate-your-state#:~:text=CMS%20reimburses%20each%20state%20for,typically%20have%20a%20higher%20FMAP)

Telecommunications fees

988 is meant to serve entire regions in a manner similar to 911. 988 contact center funding and integrated crisis care services might be best served through a population-based funding stream that comes from an assessment on cell phone and/or land line, like 911. This approach would more simply sustain nationwide funding for this safety net service and implementation of advanced air-traffic-control type technology in all parts of the country.¹⁴⁶

The National Suicide Hotline Designation Act enables states to pass legislation assessing monthly fees on cell phone bills to support 988 and integrated crisis care services. This is similar to what is often done to support 911 services. Even if your state does not assess a 911 fee, legislation can be introduced for 988 assessments in state legislatures. Several states, including Colorado, Nevada, Virginia, and Washington, have enacted such legislation. The fee level and scope of services covered by 988 telecommunications fees vary by state. For additional information (including where to find a model bill), see [“Overview of states that have enacted a 988 fee” in Legislation and oversight](#).

¹⁴⁵ Centers for Medicare & Medicaid Services, “100% FMAP for LTSS—Educate your state,” accessed February 2022, <https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/100-percent-fmap-educate-your-state#:~:text=CMS%20reimburses%20each%20state%20for,typically%20have%20a%20higher%20FMAP>.

¹⁴⁶ “National Guidelines for Behavioral Health Care,” pg. 38.

7. Legislation and oversight

Overview of the core elements of 988 legislation

State legislatures are introducing and passing legislation in preparation for the rollout of 988 and to support integrated crisis care more broadly. NASMHPD has drafted a model bill for core BH crisis services systems as a reference for states / territories to use when considering 988 legislation. The core elements of model legislation include:¹⁴⁷

- 988 contact centers
- Mobile crisis services
- Crisis receiving and stabilization services
- A 988 fund to protect 988 fees, appropriations, and other funding sources
- A funding mechanism to support 988 (e.g., telecommunications fees)
- Planning, collaboration, and oversight committees
- Timeframes to accomplish the provisions of the legislation that are consistent with the timeframes required by the National Suicide Hotline Designation Act of 2020 and the Federal Communication Commission’s rules adopted on July 16, 2020

Examples of model core elements of state legislation enacted or in committee

State	Core element included	Details
Virginia (S.B. 1302) ¹⁴⁸	988 contact centers and crisis care system	Enacted a comprehensive crisis system designed to ensure that BH experts are involved in responding to individuals in crisis. ¹⁴⁹ The system is comprised of: <ul style="list-style-type: none"> • Crisis call centers • Community care and MCTs • Crisis stabilization centers
Washington (H.B. 1477) ¹⁵⁰	Crisis services and oversight committees for specific populations	Created a 988 tribal BH and suicide prevention line and tribal 988 subcommittee ¹⁵¹

¹⁴⁷National Association of State Mental Health Program Directors, “Model bill for core state behavioral health services systems,” April 16, 2021 draft, accessed February 2022, <https://www.nasmhpd.org/sites/default/files/Model%20Bill%20for%20a%20Core%20State%20Behavioral%20Health%20Crisis%20Services%20System.pdf>.

¹⁴⁸ Virginia’s Legislative Information System, “SB 1302 crisis call center fund; created, collection of 988 charges,” accessed February 2022, <https://lis.virginia.gov/cgi-bin/legp604.exe?212+sum+SB1302&212+sum+SB1302>.

¹⁴⁹ “Marcus Alert,” City of Virginia Beach, accessed February 2022, <https://www.vbgov.com/government/departments/human-services/behavioral-health/Pages/marcus-alert.aspx#:~:text=%E2%80%8BMarcus%20Alert%2C%20sometimes%20called,Beach%20is%20one%20of%20the>.

¹⁵⁰ “HB 1477 – 2021-22,” Washington State Legislature, accessed February 2022, <https://app.leg.wa.gov/bills/summary?BillNumber=1477&Year=2021>.

¹⁵¹ Stephanie Hepburn, “Washington State’s 988 legislation includes a 988 tribal crisis line,” #CrisisTalk, August 3, 2021, <https://talk.crisisnow.com/washington-states-988-legislation-includes-a-988-tribal-crisis-line/#:~:text=The%20hub%20and%20988%2C%20points%20out%20Lowe%2C%20are,connecting%20people%20to%20the%20new%20tribal%20crisis%20line>.

State	Core element included	Details
Washington (continued)	Crisis services and oversight committees for specific populations (continued)	Moved to enhance and expand the availability of crisis services to respond to the unique needs of specific populations, including: ¹⁵² <ul style="list-style-type: none"> • Children • LGBTQ+ youth • Geriatric populations, including older adults of color and older adults with comorbid dementia
Utah (S.B. 155) ¹⁵³	Oversight committee	Expanded the membership and duties of its existing Behavioral Health Crisis Response Commission to oversee 988 implementation (rather than creating a new, separate committee)
California (A.B. 988) ¹⁵⁴	Collaboration and oversight committee	Moved to establish a 988 Local Planning Council responsible for implementing guidelines, standards, and regulations to support 988 and integrated crisis care. Members include: <ul style="list-style-type: none"> • Office of Emergency Services • California Health and Human Services Agency • County BH-crisis services
Texas (S.B. 1) ¹⁵⁵	Study to assess benefits of 988	A 988 study was put forth as an additional provision to another bill under consideration by the legislature to assess: ¹⁵⁶ <ul style="list-style-type: none"> • The NSPL infrastructure • Strategies to improve linkages between NSPL and crisis services • Strategies to improve access and mental health crisis and suicide response • Recommendations to fund NSPL and crisis response services <p>The objective of the study is to articulate the benefits and needs for legislation to support 988 and integrated crisis care¹⁵⁷</p>

- **Additional resources:**

- [NASMHPD](https://www.nasmhpd.org/sites/default/files/FINAL_988_Model_Bill_2-22-22_edited.pdf) Model Bill for Core State Behavioral Health Crisis Services Systems (https://www.nasmhpd.org/sites/default/files/FINAL_988_Model_Bill_2-22-22_edited.pdf)
- [NASMHPD](https://www.nasmhpd.org/sites/default/files/NASMHPD_988_Model_Bill_Slides.pdf) Model Bill for Core State Behavioral Health Crisis Services Systems slides (https://www.nasmhpd.org/sites/default/files/NASMHPD_988_Model_Bill_Slides.pdf)
- [NASMHPD](https://www.nasmhpd.org/sites/default/files/2022_nasmhpd_StatesLegislating988_022922_1753.pdf) States' Experiences in Legislating 988 and Crisis Services Systems (https://www.nasmhpd.org/sites/default/files/2022_nasmhpd_StatesLegislating988_022922_1753.pdf)
- [NAMI](https://www.quorum.us/dashboard/external/mgWzdPqJLWHohzOhdRWE/) 988 State Bill Tracking, with links to legislation (https://www.quorum.us/dashboard/external/mgWzdPqJLWHohzOhdRWE/)

¹⁵² "HB 1477 – 2021-22," Washington State Legislature, accessed February 2022.

¹⁵³ Utah State Legislature, "S.B. 155 988 Mental Health Crisis Assistance," accessed February 2022, <https://le.utah.gov/~2021/bills/static/SB0155.html>.

¹⁵⁴ California Legislative Information, "AB-988 Mental health: 988 crisis hotline 2021-2022," June 22, 2021, accessed February 2022, https://leginfo.legislature.ca.gov/faces/billNavClient.xhtml?bill_id=202120220AB988.

¹⁵⁵ Texas Legislature Online, "S.B. No. 1, General appropriations act, Eighty-seventh legislature," accessed February 2022, <https://capitol.texas.gov/tlodocs/87R/billtext/pdf/SB00001F.pdf>.

¹⁵⁶ Texas Legislature Online, "S.B. No. 1," pg. 179, accessed February 2022.

¹⁵⁷ Interview with Greg Hansch, Executive Director of NAMI Texas, February 2022.

Overview of states that have enacted a 988 fee

State	Considerations	Fee	Scope of services	Additional information
Colorado ¹⁵⁸	<ul style="list-style-type: none"> • Medicaid expansion state • Population—5.8 million • Rural—12.3 percent 	Current fee: \$0.18 Capped at \$0.30 ¹⁵⁹	<ul style="list-style-type: none"> • 988 crisis hotlines • Services providing crisis outreach, stabilization, and acute care to individuals calling the 988 crisis hotline¹⁶⁰ 	~\$14 million in expected fee revenue is based on a monthly 18-cents per line to cover the costs of Vibrant and Colorado's projected contact volumes plus additional MCTs needed to support increased demand in 988 / crisis services ¹⁶¹
Nevada ¹⁶²	<ul style="list-style-type: none"> • Medicaid expansion state • Population—3.1 million • Rural—9.3 percent 	Capped at \$0.35 ¹⁶³	<ul style="list-style-type: none"> • 988 call routing • Crisis outreach and stabilization services responding to 988 calls¹⁶⁴ 	~\$13.5 million in expected fee revenue is based on a monthly 35-cents per line, which is estimated to cover at least 70 percent of costs based on Vibrant and Nevada's own projected volumes ¹⁶⁵
Virginia ¹⁶⁶	<ul style="list-style-type: none"> • Medicaid expansion state • Population—8.6 million • Rural—12.0 percent 	Recurring wireless accounts: \$0.12 Prepaid accounts: \$0.08 ¹⁶⁷	Establishing and administering crisis call centers in accordance with: ¹⁶⁸ <ul style="list-style-type: none"> • Mobile crisis teams • Stabilization services 	Virginia expects the 988 fund to receive \$9.2 million in FY22 and \$10 million in FY23 and each year after, which covers the costs of establishing a crisis hotline, staffing, and maintenance ¹⁶⁹

¹⁵⁸ "Co-author Of USAID-commissioned assessment on rapid expeditionary development teams discusses feedback, messages in Devex interview," Kaiser Family Foundation, June 12, 2019, <https://www.kff.org/medicaid/issue-brief/status-of-state-medicaid-expansion-decisions-interactive-map/>; <https://www.census.gov/quickfacts/CO>.

¹⁵⁹ "NAMI State 988 Bill Tracker," National Alliance on Mental Illness, accessed February 2022, <https://www.quorum.us/spreadsheet/external/KyTUjdpKHIZfuecFyBja/>.

¹⁶⁰ "NAMI State 988 Bill Tracker," National Alliance on Mental Illness, accessed February 2022.

¹⁶¹ Interview with Moe Keller, Vice President of Public Policy and Strategic Initiatives, Mental Health America, February 2022.

¹⁶² "Quick facts Nevada," United States Census Bureau, accessed February 2022, <https://www.census.gov/quickfacts/NV>; <https://www.ruralhealthinfo.org/states/Nevada>.

¹⁶³ "NAMI State 988 Bill Tracker," National Alliance on Mental Illness, accessed February 2022.

¹⁶⁴ "NAMI State 988 Bill Tracker," National Alliance on Mental Illness, accessed February 2022.

¹⁶⁵ Interview with Stephanie Woodard, State Mental Health Authority and the Single State Authority for Substance Abuse, Nevada Division of Public and Behavioral Health, February 2022.

¹⁶⁶ "Quick facts Virginia," United States Census Bureau, accessed February 2022, <https://www.census.gov/quickfacts/VA>; <https://www.ruralhealthinfo.org/states/virginia>.

¹⁶⁷ Legiscan, "Virginia Senate Bill 1302," March 18, 2021, accessed February 2022, <https://legiscan.com/VA/text/SB1302/id/2351668>.

¹⁶⁸ Legiscan, "Virginia Senate Bill 1302," March 18, 2021, accessed February 2022.

¹⁶⁹ Arlene Hahn Stephenson, "States' experiences in legislating 988 and crisis services systems," Vibrant Emotional Health and the National Association of State Mental Health Program Directors, February 2022, https://www.nasmhpd.org/sites/default/files/2022_nasmhpd_StatesLegislating988_022922_1753.pdf.

State	Considerations	Fee	Scope of services	Additional information
Washington ¹⁷⁰	<ul style="list-style-type: none"> • Medicaid expansion state • Population—7.7 million • Rural—9.9 percent 	Initial fee: \$0.24 Fee in 2023: \$0.40 ¹⁷¹	988 call routing Services responding to 988 calls to include: <ul style="list-style-type: none"> • Acute BH services • Crisis outreach • Stabilization services • Follow-up case management¹⁷² 	Washington estimates it will receive a \$23 million appropriation for call routing, center operations, and call center hubs, and \$1 million for a tribal crisis line ¹⁷³

8. Technology

Technology has opened a new frontier in mental health and substance use crisis care. System interoperability enables the provision of timely and quality care, which leads to better health outcomes for individuals in crisis and their families. States / territories have an opportunity to build the necessary infrastructure to enhance crisis services across the entire continuum and allow all members of the community to access care in moments of crisis.

States / territories can begin to build or improve upon their current technology infrastructure by integrating platform capabilities, establishing interoperability across crisis services, and managing / monitoring core systems and databases that support the state- / territory-wide crisis system.

Integrating crisis capabilities to improve outcomes

Vibrant Emotional Health’s Unified Platform

Vibrant Emotional Health, the administrator of the NSPL, is developing a unified technological platform that is interoperable within and across crisis and emergency response systems as well as with the administrator of 988.¹⁷⁴ The platform will support calls, chats, texts, and emails, and aims to improve caller experience, counselor effectiveness, routing capabilities, and contact analytics.¹⁷⁵

The unified platform is comprised of two components: a Contact Center System (CCS) and a Customer Relationship Management system (CRM). While the CCS helps track omni-

¹⁷⁰ “Quick facts Washington,” United States Census Bureau, <https://www.census.gov/quickfacts/fact/table/WA/PST045221>; <https://www.ruralhealthinfo.org/states/washington>.

¹⁷¹ “HB 1477 – 2021-22,” Washington State Legislature, accessed February 2022.

¹⁷² “HB 1477 – 2021-22,” Washington State Legislature, accessed February 2022.

¹⁷³ Arlene Hahn Stephenson, “States’ experiences in legislating 988,” February 2022.

¹⁷⁴ Vibrant Emotional Health, “988 serviceable populations and contact volume projections,” December 2020, accessed February 2022, https://www.vibrant.org/wp-content/uploads/2020/12/Vibrant-988-Projections-Report.pdf?_ga=2.62739180.1718066263.1611784352-1951259024.1604696443.

¹⁷⁵ Vibrant Emotional Health, “Unified platform: benefits, implementation, and schedule,” June 2021, accessed February 2022.

channel interactions and expands visibility into contact center operations, the CRM provides the following capabilities:¹⁷⁶

- Assessment of immediate risks
- Development of safety plans
- Scheduling and tracking of follow-ups
- Coordination and tracking of emergency rescues
- Analytics and reporting
- Secure data sharing with external entities
- Quality assurance reviews of completed contacts

States / territories and contact centers may choose whether or not to adopt the unified platform. The unified platform is expected to go live in Q4 of 2022, with the expanded rollout in 2023.¹⁷⁷ The table below shows the development timeline for the functionality within the unified platform.¹⁷⁸

Timeline	Functionality
Development through November 2022	Omni-channel contact center system <ul style="list-style-type: none"> • Automatic call distribution (ACD) and skills-based routing • Geo-location-based routing (pending FCC approval) CRM system <ul style="list-style-type: none"> • Call reports • Follow-up • Medicaid billing preparedness • Resource database • MCT database Centralized Identity and Access Management (IAM)
Future enhancements under consideration	MCT dispatching Bed registries Alternate lines of business

Establishing interoperability across services to enhance crisis response

Building partnerships with PSAPs is critical to clarifying the differences in and establishing interoperability between 988 and 911. States / territories can make concerted efforts to communicate and collaborate with these partners as a way of integrating services to support crisis care.

¹⁷⁶ Vibrant Emotional Health, "Technical details of the unified platform," accessed February 2022.

¹⁷⁷ Vibrant Emotional Health, "988 unified platform kick-off meeting," January 2022.

¹⁷⁸ Vibrant Emotional Health, "988 unified platform kick-off meeting," January 2022.

Case study: Nevada's 988 / 911 Interoperability Workgroup to integrate 988 and 911¹⁷⁹

As part of its 988 planning process, Nevada established a 988 / 911 Interoperability Workgroup to ensure a seamless, bi-directional transfer of calls between 988 and 911. The workgroup consists of the Nevada Association of Counties (NACO), the Nevada Sheriffs' and Chiefs' Association (NVSCA), and state-wide PSAPs.

Through the 988 / 911 Interoperability Workgroup, Nevada was able to identify:

- Information about its PSAPs
 - Geographic regions served
 - Ability to port calls to 988
 - Dispatch protocol technologies used
 - Needs to support 988 / 911 interoperability
- Concerns around 988 and 911 integration
 - Need for procedures to ensure safety and mitigate liability
 - Lack of protocols to route calls to 988
 - Lack of infrastructure, workforce, and training to properly route calls
 - Lack of technology capabilities to support non-manual call transfers
- Steps to build processes and capabilities to support 988 / 911 interoperability
 - Review / adopt other state processes and in-state systems for diverting calls from 911 to 988
 - Explore technological solutions to support call transfers to and from 988 and 911
 - Continue to build relationships between 988 and PSAPs for collaboration and connection

The Interoperability Workgroup meets monthly, and its efforts are the beginning steps to establishing a robust technology network to support integrated crisis care.

Managing / monitoring systems and databases to support crisis services

One key role of states / territories in delivering crisis services is managing and monitoring the core technology systems and databases that support these services. Integration of systems across the crisis continuum enables functionality such as the monitoring of patient care journeys using CRM systems, communication between contact centers and mobile crisis systems, mobile GPS dispatch, appointment scheduling, and identifying the appropriate care for patients using bed registries.

States / territories can structure systems and databases to support crisis systems in various ways. Below is an example of how Georgia has arranged their technology infrastructure to support crisis services.

¹⁷⁹ Interview with Stephanie Woodard, February 2022.

Georgia's crisis systems infrastructure

Georgia's crisis systems infrastructure is fairly centralized. The systems used to receive and respond to crisis calls are owned by the contact centers but monitored by the Department of Behavioral Health and Developmental Disabilities (DBHDD). Some distinguishing elements of Georgia's system include: ¹⁸⁰

- Standardized registration of caller information by contact centers, which is used for CRM purposes
- Integration of mobile crisis with contact center systems, which enables the sharing of contact disposition data to response teams
- Mobile crisis geo-location functionality, which is funded and monitored by DBHDD
- Appointment scheduling capabilities, which can be completed by contact centers, mobile crisis, and crisis receiving and stabilizing facilities
- Statewide live bed registry database for all state-funded crisis receiving facilities

9. Data and performance management

Data and performance management are critical for the effectiveness of crisis systems. Data, when converted to metrics and compared against a standard of success, can be a powerful tool in improving system performance. States / territories can use this information to monitor and manage the performance of crisis services within the state / territory and shore up any deficiencies and inequities to improve quality and access to care.

To improve crisis care, states / territories can identify key data points and performance indicators that define success for crisis services, develop the systems infrastructure to manage performance across the crisis system, and hold providers accountable for performing at the level established by the state / territory.

Introduction to the importance of data and KPIs to support integrated crisis care

Establishing KPIs and processes to monitor performance is a key component of creating effective crisis systems. States and territories can identify gaps within crisis systems and resolve data reporting discrepancies by establishing a robust performance management infrastructure.

Below are examples of key data points and performance indicators that states / territories can consider collecting and monitoring to ensure equitable access to timely, affordable, and quality crisis care. ¹⁸¹

¹⁸⁰ Interview with Anna Bourque, Director of Administrative Services Organization Coordination at State of Georgia Department of Behavioral Health and Developmental Disabilities, February 2022.

¹⁸¹ SAMHSA's "National Guidelines for Behavioral Health Care," pg. 51; Input from Ted Lutterman, Director of Research, NRI, February 2022.

Crisis service	Data points	KPIs
Crisis contact center	<ul style="list-style-type: none"> • Number of calls • Reasons for calls • Number of unique episodes / callers • Personal information (for appointment scheduling) • Demographic information • Insurance information • Call escalation (e.g., mobile crisis, crisis facility, first responder) 	<ul style="list-style-type: none"> • Answer rate • Answer speed • Average handle time • Talk time • Abandonment rate • Rate of calls resolved through the contact center • Rate of individuals who were connected to appropriate resources / follow-on care • Follow-up rate post contact
Mobile crisis response	<ul style="list-style-type: none"> • Number of teams dispatched / patients served • Referral source (initiator of the mobile response) • Number of teams dispatched with police • Coordination with other rescue services • Personal information (for appointment scheduling) • Demographic information • Insurance information • Discharge destination 	<ul style="list-style-type: none"> • Time to arrival / response time • Rate of crises resolved via mobile response • Rate of individuals who were connected to appropriate resources / follow-on care • Follow-up rate post mobile response
Crisis receiving and stabilizing facility	<ul style="list-style-type: none"> • Admissions / number of patients served • Number of voluntary admissions • Number of referrals by: <ul style="list-style-type: none"> ○ Police / first responders ○ MCTs ○ Hospitals / clinical professionals • Demographic information • Insurance information • Discharge location 	<ul style="list-style-type: none"> • Average length of stay • Readmission rate • Diversion rate • Rate of individuals who were connected to appropriate resources / follow-on care • Follow-up rate post care

- **Additional resources**

- [SAMHSA National Guidelines – Monitoring System and Provider Performance \(https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf\)](https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf)
- [NSPL Call Center Metrics \(https://suicidepreventionlifeline.org/wp-content/uploads/2019/02/CallCenterMetrics_final.pdf\)](https://suicidepreventionlifeline.org/wp-content/uploads/2019/02/CallCenterMetrics_final.pdf)

How states / territories can establish performance management systems

States / territories can influence the effectiveness of crisis care by establishing data and performance management systems for service providers. The following components are important to consider when building the infrastructure to monitor and manage crisis services performance at the state / territory level:

- Standardized definitions and practices on which data to collect and share across providers
- Systems integration (between providers and the state BH authority) for data sharing
- Interfaces to view and translate data into performance measurements

Tennessee has developed and implemented the data and performance management infrastructure to improve crisis care across the state.

Case study: Tennessee's performance management infrastructure¹⁸²

Tennessee’s Department of Mental Health and Substance Abuse Services (DMHSAS) has created the data and systems infrastructure to monitor and manage performance across its crisis system. DMHSAS implemented this system in 2021 in response to providers voicing concerns about underfunded areas within the crisis continuum.

While the state’s older system captured information about callers and outcomes related to face-to-face crisis service encounters, it did not allow DMHSAS to track how people moved through the overall crisis system or whether the crisis intervention resulted in diversion from higher levels of care. To close the gaps within the crisis system, the DMHSAS commissioner convened a variety of stakeholders, including DMHSAS staff, internal IT partners, TennCare (Medicaid), hospital services, and providers, to enhance and standardize data collection methods.

To standardize its state-wide data collection methods, Tennessee established a comprehensive service data dictionary and procedures on how to capture key data elements for phone and face-to-face assessments. Examples of data entry interfaces are highlighted below.

Services interface:

Provider	Pathways of Tennessee, Inc.	Provider Patient No		SSN		Gender	Select
First Name		Last Name		DOB		Service	Select
County of Residence	Select	Payor Billed for Service	Select	Primary Insurer	Select	County of Service	Select
DOS or Admit Date		Discharge Date		Duration (Hours)			

Save Cancel

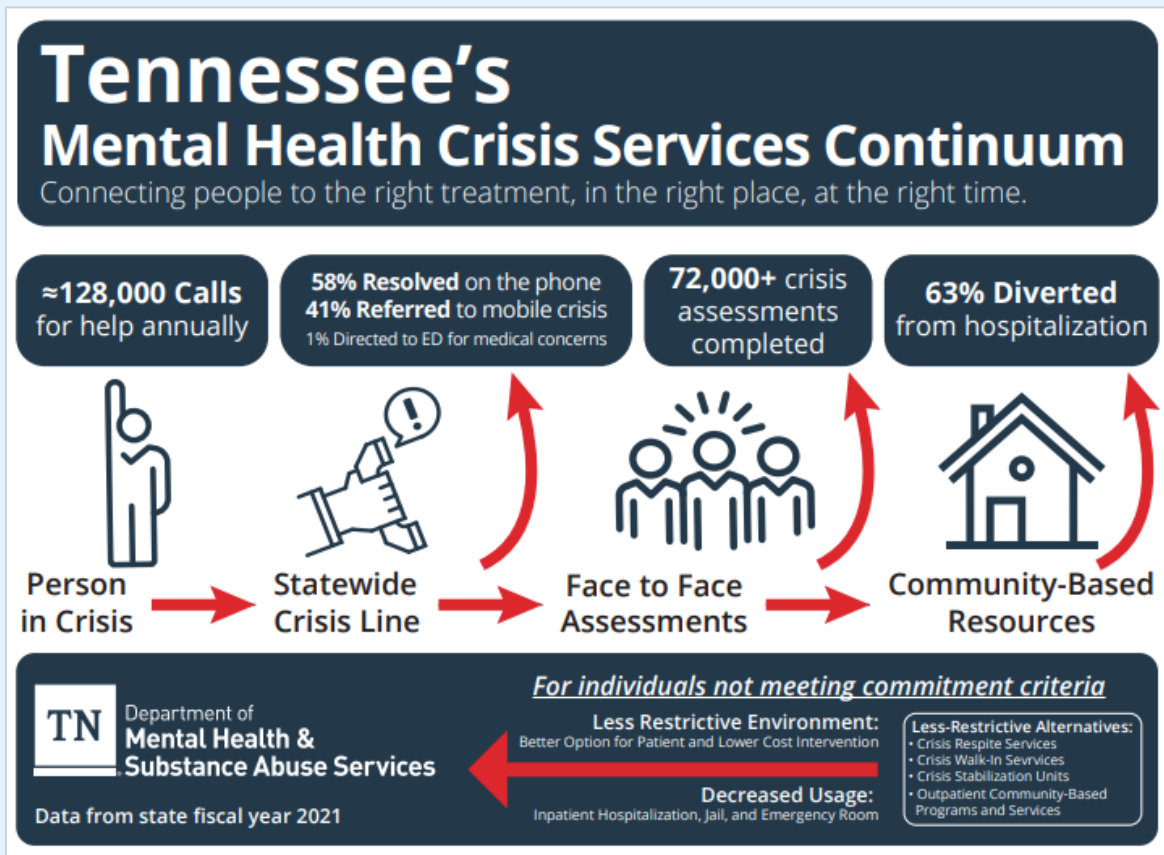
¹⁸² Interview with Kristin Neylon, Project Manager and Senior Project Associate, National Association of State Mental Health Program Directors Research Institute, March 2022.

Crisis face-to-face assessment interface:

Assessment Type <input type="text"/>	Consumer Location at Assessment <input type="text"/>
Assessment Date <input type="text"/>	Crisis Assessment via Televideo <input type="radio"/> Yes <input type="radio"/> No
Arrival Time <input type="text"/> : <input type="text"/> AM <input type="radio"/> PM	Current Services Being Received <input type="text"/>
Transported by Law Enforcement <input type="radio"/> Yes <input type="radio"/> No	Declaration of MH Treatment <input type="text"/>
Primary Insurer <input type="text"/>	MOT Status <input type="text"/>
Payor Billed for Service <input type="text"/>	Durable POA/Conservator/Guardian <input type="text"/>
Annual Gross Household Income <input type="text"/>	
Number of People in Household <input type="text"/>	
Residential Status <input type="text"/>	Marital Status <input type="text"/>
County of Residence <input type="text"/>	Military Status <input type="text"/>
Employment Status <input type="text"/>	Attended school in last 3 months <input type="text"/>
Number of arrests in last 30 days <input type="text"/>	Current or highest grade completed <input type="text"/>

Currently, Tennessee collaborates with its providers to monitor and manage crisis care performance through a single platform and series of data dashboards. This allows DMHSAS to monitor an individual’s journey through the crisis services system and ensure they receive quality care at the appropriate level in a timely fashion. The system, which is connected to the Tennessee statewide crisis line and may not include all Tennessee calls to the Lifeline, provides weekly reports on:

- How many individuals in the past week were referred to a higher level of care
- The number of individuals waiting for a bed in a crisis stabilization unit (compared to the census)
- Which resources and services were offered to try to prevent diversion



If an individual's crisis results in inpatient hospitalization, DMHSAS can look back at the services and resources the individual in crisis was offered to ensure that every opportunity to divert the individual from inpatient hospitalization was exhausted.

Tennessee's robust systems and data infrastructure, along with its systematic review of performance metrics, enables DMHSAS to monitor what is working well in its crisis system and identify / resolve any gaps within the system.

How states / territories can use contract language to set performance standards

States / territories have a critical role to play in setting performance standards and improving access to care, which can be achieved by establishing contractual provisions with crisis services providers. Through the language of the contracts arranged with providers, states / territories can mandate which data must be collected, which metrics must be reported and when, and specific populations that must be served and in what capacity. The contract language used by states / territories can help improve access to care and reduce health inequities.

Case study: Arizona's data and performance requirements for contracted providers¹⁸³

The Arizona Health Care Cost Containment System (AHCCCS) sets data collection, reporting, and service requirements for its contracted providers. AHCCCS has not only outlined which metrics must be collected by contractors for contact centers, mobile crisis, and crisis receiving and stabilizing facilities, but also the performance standards providers must meet. In addition, it requires that contracted health plans participate in a data and information sharing system, which connects crisis providers and member physicians through a health information exchange to increase communication, transparency, and accountability.

AHCCCS emphasizes the importance of health equity and improved access to crisis services for all members of the community. As examples, AHCCCS requires that contractors must:

- Have access to and provide crisis services on tribal lands
- Incorporate peer and family support services when providing crisis services
- Develop and implement a Health Disparity Summary and Evaluation Report that provides an analysis of the effectiveness of strategies and interventions in meeting its health equity goals¹⁸⁴

¹⁸³ Interview with CJ Loisel, Crisis Administrator at Arizona Health Care Cost Containment System, February 2022.

¹⁸⁴ Arizona Health Care Cost Containment System, "Regional behavioral health authority: Maricopa County, Section A: Contract amendment," October 1, 2021, https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/RBHAs/RBHA_MARICOPA_100121_AMD16_FINAL.pdf.

The AHCCCS' data and performance management standards are integral to enhancing the quality of care and the effectiveness of the overall crisis delivery system, which then lead to better, more equitable health care outcomes and contain costs.

- Additional resources
 - [AHCCCS Contract framework and details](https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/RBHAs/RBHA_MARICOPA_100121_AMD16_FINAL.pdf)
(https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/RBHAs/RBHA_MARICOPA_100121_AMD16_FINAL.pdf)
 - [AHCCCS Crisis services requirements](https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH20/AMPM590.pdf)
(<https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH20/AMPM590.pdf>)
 - [AHCCCS Contractor data / metrics reporting template](https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH20/AMPM590A.pdf)
(<https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH20/AMPM590A.pdf>)

III. Tribal nations

As with other BH needs, the needs of tribes related to crisis care are unique and diverse. Crisis services will need to account for demographics, history, cultural awareness, impact of native culture on health beliefs and health-seeking behavior, and heritage, along with other influences. They should also consider the history of disparities in access to healthcare services, funding, and resources.

As outlined in SAMHSA’s Behavioral Health Services for American Indians and Alaska Natives,

“American Indians and Alaska Natives have consistently experienced disparities in access to healthcare services, funding, and resources; quality and quantity of services; treatment outcomes; and health education and prevention services. Availability, accessibility, and acceptability of BH services are major barriers to recovery for American Indians and Alaska Natives. Common factors that influence engagement and participation in services include availability of transportation and childcare, treatment infrastructure, level of social support, perceived provider effectiveness, cultural responsiveness of services, treatment settings, geographic locations, and tribal affiliations.”¹⁸⁵

988 presents a unique opportunity to increase engagement between tribes and other stakeholders, including federal, state, and local governments, so they can better work together to improve access to crisis care. The role of tribal nations in preparing for 988 may differ significantly among different tribes, depending on their size, current resources and needs, and specific contexts.

While some tribes may explore funding their own crisis systems to include call centers, others may focus on communicating about crises and dialing 988, and on establishing partnerships with law enforcement and first responders to address jurisdictional constraints within tribal communities. In addition, the unique circumstances and challenges facing tribal nations—e.g., their special government-to-government relationship with the federal government, their status as sovereign nations and the relationships they have with states, access to crisis services in remote locations, and adequate funding for crisis care—will need to be understood and negotiated to ensure tribal voices are fully represented in the 988 planning process and design of broader crisis care systems.

This section presents examples of the roles tribal nations have played and may play in preparing for 988 and building robust crisis systems that address tribal needs. This information is intended to serve as a high-level starting point. More detailed information specific to tribes is forthcoming.

¹⁸⁵ Substance Abuse and Mental Health Services Administration, “Behavioral health services for American Indians and Alaska Natives: Treatment improvement protocol (TIP) Series 61, HHS Publication No. (SMA) 18-5070EXSUMM, 2018, hsa.gov/sites/default/files/d7/priv/tip_61_aian_full_document_020419_0.pdf.

Lifeline contact center capacity and crisis system planning

Engagement of tribes with state-level stakeholders is critical to ensure that the needs of tribal nations can be addressed by 988, including ensuring capacity and access to culturally appropriate resources for members of tribal nations. It is important that this engagement takes place as state planning grant committees are developing strategic plans to prepare for 988 and outlining infrastructure needs to handle expected call volumes.

Washington State created a 988 tribal BH and suicide prevention line, which includes \$1 million in funding to develop and operate the line and a tribal 988 subcommittee.¹⁸⁶ The subcommittee, which includes representation from the American Indian Health Commission, is providing direction with respect to the needs of tribes that relate to the 988 system.¹⁸⁷

New Mexico has convened a 988 planning tribal workgroup, with representation from 23 tribes and pueblos. This work group has provided input on how Lifeline call centers can effectively serve the needs of tribes.¹⁸⁸

Crisis care and behavioral health care capacity

Workforce and resource calculators can help to estimate the optimal crisis system resource allocations needed to meet the needs of specific communities. Three examples of workforce calculators are highlighted below; each allows for the calculation of specific resources based on input parameters.¹⁸⁹

Use case	Calculator type	Inputs	Outputs
Calculating Lifeline contact center staffing needs to meet service levels	Erlang calculator ¹⁹⁰	<ul style="list-style-type: none"> Number of phone calls Time period (e.g., per half hour) Average call duration (average handling time) Service level or percentage of calls answered within a period of time (e.g., 80 percent of calls in 20 seconds) 	Number of contact operators needed to meet the service level target
Calculating mobile crisis capacity and number of crisis beds / chairs	Crisis Now Crisis Resource Need Calculator ¹⁹¹	<ul style="list-style-type: none"> Population census Average length of stay (of acute inpatient) Average cost of acute bed (per day) 	Number of resources needed for the following: <ul style="list-style-type: none"> MCTs Acute inpatient beds Short-term beds Crisis receiving chairs

¹⁸⁶ Stephanie Hepburn, "Washington State's 988 legislation includes a 988 tribal crisis line," August 3, 2021.

¹⁸⁷ "HB 1477 – 2021-22," Washington State Legislature, accessed February 2022.

¹⁸⁸ Interview with Neal Bowen, Director of the Behavioral Health Sciences Division, Human Services Department, State of New Mexico, February 2022.

¹⁸⁹ "National Guidelines for Behavioral Health Care," pg. 42.

¹⁹⁰ "Erlang calculator," accessed February 2022.

¹⁹¹ "Crisis Resource Need Calculator," accessed February 2022.

Use case	Calculator type	Inputs	Outputs
Calculating mobile crisis capacity and number of crisis beds / chairs (continued)	<u>Crisis Now Crisis Resource Need Calculator</u> (continued) ¹⁹¹	<ul style="list-style-type: none"> Additional customization based on state / territory cost models can be included 	<p>Costs associated with resources</p> <p>Potential cost savings</p>
Calculating staffing needs for crisis receiving and stabilizing facilities	<u>Crisis Now Staffing Calculator</u> ¹⁹²	<ul style="list-style-type: none"> Percentage served under involuntary commitment Percentage served via law enforcement drop-off Number of admissions per day Average length of stay Average number of seclusion and restraints per day Average program census Number of one-on-one assignments in the program 	<p>Number of staff required for the following roles:</p> <ul style="list-style-type: none"> Provider staff (e.g., psychiatrists, nurse practitioners) Nursing staff Clinicians Peer and BH workers <p>Costs associated with staffing</p>

Partnering with states to increase access to crisis services for tribal members

Given the status of tribes as sovereign nations, there can be limitations regarding access to medical care and crisis services for tribal members within a state. For example, if authorization is required for state rescue units to go onto tribal reservations, this could be a barrier to delivering care. In addition, tribal members whose reservations span multiple states could face challenges covering the costs of medical services in one state versus another. Engagement with tribes by states should occur on an individual basis when developing crisis services to ensure tribal members receive quality, affordable, and timely care, which can help to address the challenges above.¹⁹³

Tribes have the right to exclude persons from tribal lands and it is important for tribes to clarify under which scenarios a formal agreement is required for state or county rescue units to go onto reservations. There may be some instances, such as voluntary requests, where tribes may not require rescue units to obtain permission to enter reservations to provide services to tribal members. However, if law enforcement is involved or the response is for an involuntary commitment, tribes may prefer that tribal or BIA officers respond to the crisis or require that state responders obtain a tribal court order to access the reservation.¹⁹⁴

Tribes could also consult with states about financial coverage for crisis services (e.g., mobile crisis on-scene, a crisis receiving facility). They could help facilitate conversations with the state and local IHS facilities to outline the best approach for providing crisis services to tribal members. In general, all IHS beneficiaries are eligible for care at any IHS facility. However, if tribal members receive services or care outside of the IHS network of providers and services,

¹⁹² "Crisis resource staffing calculator," accessed February 2022.

¹⁹³ Interview with Pamela End of Horn, February 2022.

¹⁹⁴ Interview with Pamela End of Horn, February 2022.

then the state and state / county rescue units need to understand IHS' [Purchased / Referred Care \(PRC\)](https://www.ihs.gov/prc/) process (<https://www.ihs.gov/prc/>).¹⁹⁵

To establish best practices for administering crisis services and care to tribal members, tribes could consider:¹⁹⁶

- Initiating consultations with state health authorities
- Consulting with states and BIA regarding jurisdiction matters
- Facilitating conversations with states and the local IHS facilities to initiate services

Communications and external engagement

Although messaging to the public may not begin until after July 2022, states and territories have begun to develop strategies for communications about 988 as part of the 988 planning process.

As part of the 988 communications process, tribal nations can:

- Work with federal partners and states to ensure:
 - Overall messaging strategies address the unique needs of tribes and messages are delivered through channels intended to reach tribal members
 - Messaging and material are culturally appropriate for and meet the diverse needs of tribal nations
- Develop plans for messaging campaigns within tribal communities to ensure individuals know about and understand 988, as relevant for specific tribal nations

Prior to the July 2022 transition to 988, communication is best centered on basic information about 988 and engaging with partners who play a role in BH crisis care delivery. Specific topics that will likely be key components of the initial communications are:

- **What 988 is, how it works, and how it fits into the crisis service ecosystem:**
 - 988 is the new dialing code that provides direct, life-saving services to people experiencing mental health and substance use crises, or the family members and advocates of those in need, through the *existing* NSPL.¹⁹⁷ When people call, text, or chat 988, they will be connected to trained counselors that are part of the existing NSPL network. These trained counselors will listen, understand how their problems are affecting them, provide support, and connect them to resources if necessary.¹⁹⁸
 - Any tribal member with access to an active phone and coverage, a working landline, or prepaid phone with available minutes can dial 988, reach the NSPL network, and be connected to a trained counselor. Those dialing from a mobile line whose area code is different than their physical location may not be connected with the closest contact center. However, their call will still be answered. Follow-on services, like mobile crisis or rescue response, would need to be coordinated between the contact center and available resources at the tribal member's location.

¹⁹⁵ Interview with Pamela End of Horn, February 2022.

¹⁹⁶ Interview with Pamela End of Horn, February 2022.

¹⁹⁷ "988 suicide and crisis lifeline," Substance Abuse and Mental Health Services Administration, n.d.

¹⁹⁸ "The lifeline and 988," National Suicide Prevention Lifeline, n.d.

- Additional resources for basic information on 988:
 - [SAMHSA](https://www.samhsa.gov/find-help/988) FAQ site (https://www.samhsa.gov/find-help/988)
 - [Vibrant](https://www.vibrant.org/988/) FAQ sites (https://www.vibrant.org/988/)
 - [Suicide Prevention Lifeline](https://suicidepreventionlifeline.org/current-events/the-lifeline-and-988/) The Lifeline and 988 (https://suicidepreventionlifeline.org/current-events/the-lifeline-and-988/)
 - [Suicide Prevention Lifeline](https://suicidepreventionlifeline.org/wp-content/uploads/2021/08/Back-to-Basics.png) How 988 calls are routed (https://suicidepreventionlifeline.org/wp-content/uploads/2021/08/Back-to-Basics.png)
 - [Kennedy Forum](https://www.thekennedyforum.org/988toolkit/) 988 toolkit (https://www.thekennedyforum.org/988toolkit/)
- **Relationship between 988 and 911:**
 - 988 and 911 are designed to be complementary. 911 is currently used for all emergencies, including BH emergencies. However, dispatchers may have not been trained on how to handle these types of calls. 988 is a BH crisis number. 988 counselors are trained to assist people in emotional distress, suicidal crisis, or struggles with substance use. Ongoing collaboration between 988 and 911 will help individuals in crisis get the appropriate support, providing options like MCTs in place of police or EMS responders when needed and where available.”¹⁹⁹

Integrating lived experience into crisis systems

Peers are essential to forming meaningful connections and inspiring hope for those suffering with mental health and SUDs. Their ability to remain objective, non-judgmental, and relate to those suffering is key to providing care.²⁰⁰

Peers offer their unique lived experience to provide support through advocacy, education, mentoring, and motivation.²⁰¹ Their involvement in designing crisis programs, serving as coaches and advocates for others experiencing mental health and substance use episodes, and providing crisis services strengthens the overall crisis care system.

Financial sustainability

There are multiple potential funding sources available to tribes to support crisis care. Information below outlines funds directly available to tribes as well as funding directed toward states with a requirement to fund tribal mental health and substance use services. Tribal leaders and health authorities will need to work together with state mental health, substance use, and Medicaid agencies to identify the appropriate uses of funds.

¹⁹⁹ “Framework for successful messaging,” National Action Alliance for Suicide Prevention, January 21, 2022.

²⁰⁰ Interview with Bradley Powers, The Burrell Center, January 2022.

²⁰¹ “What is a peer?,” Mental Health America, n.d.

Funding for tribes:

Federal grant funding for tribe’s behavioral health crisis services

Grant	Eligibility	Total available funding	Uses	Relevant populations
SAMHSA Tribal Opioid Response Grants (TOR) ²⁰²	<ul style="list-style-type: none"> Non-competitive grant based on population size²⁰³ Federally recognized American Indian or Alaska Native tribe or tribal organization²⁰⁴ 	FY 2021 \$37.6 million ²⁰⁵	<ul style="list-style-type: none"> Increases access to culturally appropriate evidence-based treatment Develops and provides prevention and treatment services Implements peer support, recovery coaches, spiritual support, and recovery housing services Provides treatment coverage for justice-involved patients re-entering communities²⁰⁶ 	Members of federally recognized American Indian or Alaska Native tribes
Tribal Behavioral Health Grant Program (Native Connections) ²⁰⁷	<ul style="list-style-type: none"> Federally recognized American Indian or Alaska Native tribe or tribal organization²⁰⁸ 	FY 2021 \$7.2 million ²⁰⁹	<ul style="list-style-type: none"> Develops and implements mental health, trauma, suicide, and substance abuse prevention programs serving youth:²¹⁰ <ul style="list-style-type: none"> Develop / revise protocols to ensure at-risk youth receive follow-up services Implement mental health awareness training Implement substance misuse prevention strategies 	Youth (24 and under) of federally recognized American Indian or Alaska Native tribes who are at risk of suicide and/or substance use ²¹¹

²⁰² “Tribal opioid response grants,” accessed February 2022.

²⁰³ Substance Abuse and Mental Health Services Administration, “FY 2021 tribal opioid response grants, Funding opportunity,” accessed February 2022.

²⁰⁴ “Tribal opioid response grants,” accessed February 2022.

²⁰⁵ “Tribal opioid response grants,” accessed February 2022.

²⁰⁶ Substance Abuse and Mental Health Services Administration, “FY 2021 tribal opioid response grants, Funding opportunity,” accessed February 2022.

²⁰⁷ Substance Abuse and Mental Health Services Administration, “Tribal behavioral health grant program, Funding opportunity announcement No. SM-21-011,” accessed February 2022, <https://www.samhsa.gov/sites/default/files/grants/pdf/fy-2021-tbh-foa.pdf>.<https://www.samhsa.gov/grants/grant-announcements/SM-21-011>.

²⁰⁸ Substance Abuse and Mental Health Services Administration, “Tribal behavioral health grant program, Funding opportunity,” accessed February 2022.

²⁰⁹ “Tribal behavioral health grant program,” accessed February 2022.

²¹⁰ “Tribal behavioral health grant program,” accessed February 2022.

²¹¹ “Tribal behavioral health grant program,” accessed February 2022.

Grant	Eligibility	Total available funding	Uses	Relevant populations
<u>Tribal Behavioral Health Grant Program</u>	<ul style="list-style-type: none"> Federally recognized American Indian or Alaska Native tribe or tribal organization²¹² 	FY 2021 \$7.2 million ²¹³	<ul style="list-style-type: none"> Develop and implement mental health, trauma, suicide, and substance abuse prevention programs serving youth:²¹⁴ <ul style="list-style-type: none"> Develop / revise protocols to ensure at-risk youth receive follow-up services Implement mental health awareness training Implement substance misuse prevention strategies 	Youth (24 and under) of federally recognized American Indian or Alaska Native tribes who are at risk of suicide and/or substance use ²¹⁵

Medicaid funding for tribes

Through the FMAP for LTSS program, eligible services provided to Medicaid-eligible AI / AN patients in IHS or tribal facilities can be reimbursed at 100 percent FMAP.

Since CMS reimburses these expenses fully, eligible services provided to Medicaid-eligible AI / AN patients in IHS or tribal facilities costs states nothing. With these savings, states can often afford to reimburse tribes for tribally-provided Medicaid services at an enhanced rate that is higher than 100%. Receiving an enhanced reimbursement rate from states provides tribes with more resources for LTSS.

To be eligible for 100 percent FMAP, tribal programs must meet the following requirements:²¹⁶

- LTSS must be explicitly included in a tribe's P.L. 638 contract or compact with IHS
- The tribal health department must either provide or oversee LTSS. States can either:
 - Have the state tribal health department set up a funding agreement with the tribal aging program or department to provide LTSS
 - Move the state LTSS program under the tribal health department
- The health department must bill the state Medicaid office for LTSS

²¹² "Tribal behavioral health grant program," accessed February 2022.
²¹³ "Tribal behavioral health grant program," accessed February 2022.
²¹⁴ "Tribal behavioral health grant program," accessed February 2022.
²¹⁵ "Tribal behavioral health grant program," accessed February 2022.
²¹⁶ Centers for Medicare & Medicaid Services, "100% FMAP for LTSS—Educate your state," accessed February 2022.

- **Additional resources:**
 - [CMS](https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/100-percent-fmap-educate-your-state#:~:text=CMS%20reimburses%20each%20state%20for,typically%20have%20a%20higher%20FMAP.) FMAP for LTSS (https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/100-percent-fmap-educate-your-state#:~:text=CMS%20reimburses%20each%20state%20for,typically%20have%20a%20higher%20FMAP.)

Funding for states to support services to tribes

Federal grant funding for state behavioral health crisis services with a focus on tribes

Grant	Eligibility	Total available funding	Uses	Relevant populations
SAMHSA Substance Abuse and Treatment Block Grant (SABG) ²¹⁷	<ul style="list-style-type: none"> • Non-competitive formula grant • Available to all 50 states, the District of Columbia, Puerto Rico, the U.S. Virgin Islands, six Pacific jurisdictions, and one tribal entity to prevent and treat substance abuse²¹⁸ 	FY 2022 proposed budget request is \$3.5 billion (with a 20 percent set-aside for prevention programs) ²¹⁹	<ul style="list-style-type: none"> • Helps plan, implement, and evaluate activities that prevent and treat substance abuse²²⁰ • Supplemented by Strategic Alliance Business Group (SABG), COVID-19, and American Rescue Plan (ARP) supplemental funding. Additional priority activities to enhance crisis care include the use of peer coaches in hospital emergency departments and the operation of “crisis phone lines” or “warm lines” by treatment providers²²¹ • Provides increased access, including same- / next-day appointments for those in need of SUD treatment services • Improves information technology infrastructure for providers in rural and frontier areas 	Primary target audiences include: ²²² <ul style="list-style-type: none"> • Pregnant women and women with dependent children • Intravenous drug users • Tuberculosis services • Early intervention services for HIV / AIDS • Primary prevention service Additional target populations include: ²²³ <ul style="list-style-type: none"> • Persons involved in the justice system • Persons involved in the child welfare system • Black, Indigenous, and People of Color (BIPOC) • LGBTQ+ individuals • Rural populations • Youth who are using or are at risk for using alcohol and tobacco

²¹⁷ “Substance abuse prevention and treatment block grant,” accessed February 2022.

²¹⁸ “Substance abuse prevention and treatment block grant,” accessed February 2022.

²¹⁹ Health Resources and Services Administration, “FY 2022 Justification of estimates,” pg. 2, accessed February 2022.

²²⁰ “Substance abuse prevention and treatment block grant,” accessed February 2022.

²²¹ Interview with Spencer Clark, January 2022.

²²² “Substance abuse prevention and treatment block grant,” accessed February 2022.

²²³ Interview with Spencer Clark, January 2022.

Grant	Eligibility	Total available funding	Uses	Relevant populations
SAMHSA Transformation Transfer Initiative (TTI) ²²⁴	<ul style="list-style-type: none"> Competitive -based grant Available to all 50 states, the District of Columbia, and Territories²²⁵ 	In FY 2022, 36 TTI grants of \$250,000 were awarded ²²⁶	Implements and expands 988 crisis services to include: ²²⁷ <ul style="list-style-type: none"> Increasing BH providers and expanding services Integrating specialists into mobile crisis to support LGBTQ+ needs Expanding wraparound crisis services for children and youth 	FY 2022 target audiences include: ²²⁸ <ul style="list-style-type: none"> AI / AN communities LGBTQ+ Children and adolescents

Data and performance management

How tribes can work with states to set service requirements through contract language

States have a critical role to play in setting performance standards and improving access to care, which can be achieved by establishing contractual provisions with crisis services providers. Through the language of the contracts arranged with providers, states can mandate which data must be collected, which metrics must be reported and when, and specific populations that must be served and in what capacity. Tribes can engage with state health authorities to write contracts in a way that ensures tribal members receive access to crisis services like all other US citizens without giving up sovereignty.

Arizona’s data and performance requirements for contracted providers

AHCCCS sets data collection, reporting, and service requirements for its contracted providers. AHCCCS has not only outlined which metrics must be collected by contractors for contact centers, mobile crisis, and crisis receiving and stabilizing facilities, but also the performance standards providers must meet. In addition, it requires that contracted Health Plans participate in a data and information sharing system, which connects AHCCCS’ crisis

²²⁴ “Transformation transfer initiative,” accessed February 2022.

²²⁵ “Transformation transfer initiative,” National Association of State Mental Health Program Directors, accessed February 2022.

²²⁶ National Association of State Mental Health Program Directors, “TTI 2022 Memorandum,” September 2021.

²²⁷ National Association of State Mental Health Program Directors, “Transformation transfer initiative application,” accessed February 2022.

²²⁸ National Association of State Mental Health Program Directors, “TTI 2022 Memorandum,” September 2021.

providers and member physicians through a health information exchange to increase communication, transparency, and accountability.²²⁹

AHCCCS emphasizes the importance of health equity and improved access to crisis services for all members of the community. As examples, AHCCCS requires that contractors must:²³⁰

- Have access to and provide crisis services on tribal lands
- Incorporate peer and family support services when providing crisis services
- Develop and implement a Health Disparity Summary and Evaluation Report that provides an analysis of the effectiveness of strategies and interventions in meeting its health equity goals²³¹

The AHCCCS' data and performance management standards are integral to enhancing quality of care and the effectiveness of the overall crisis delivery system, which then lead to better, more equitable health care outcomes and contain costs.²³²

- **Additional resources**

- [AHCCCS](https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/RBHAs/RBHA_MARICOPA_100121_AMD16_FINAL.pdf) Contract framework and details (https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/RBHAs/RBHA_MARICOPA_100121_AMD16_FINAL.pdf)
- [AHCCCS](https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH20/AMPM590.pdf) Crisis services requirements (https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH20/AMPM590.pdf)
- [AHCCCS](https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH20/AMPM590A.pdf) Contractor data / metrics reporting template (https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH20/AMPM590A.pdf)

²²⁹ Interview with CJ Loisel, February 2022.

²³⁰ Interview with CJ Loisel, February 2022.

²³¹ Arizona Health Care Cost Containment System, "Regional behavioral health authority: Maricopa County," October 1, 2021.

²³² Interview with CJ Loisel, February 2022.

IV. Additional Resources

Section 2: Crisis care and behavioral healthcare capacity

CallCentre Helper

Erlang Calculator for Call Center Staffing

<https://www.callcentrehelper.com/tools/erlang-calculator/>

CrisisNow

Crisis Resource Needs Calculator and Staffing Calculator

<https://crisisnow.com/tools/>

MassHealth

Massachusetts Loan Repayment Program (MLRP) for Health Professionals

<https://www.mass.gov/info-details/massachusetts-loan-repayment-program-mlrp-for-health-professionals#award-amounts->

Psychiatric Rehabilitation Association

State Recognition of the CPRP Credential

<https://www.psychrehabassociation.org/sites/default/files/images/2013-State%20Regulations.pdf>

Behavioral Health Education Center of Nebraska

Legislative Report FY 2020 and 2021

https://www.unmc.edu/bhecn/documents/bhecn_legislative_report_fy20-21_final.pdf

Section 3: Communications and external engagement

Substance Abuse and Mental Health Services Administration (SAMHSA)

988: America's Suicide Prevention and Mental Health Crisis Lifeline

<https://www.samhsa.gov/find-help/suicide-prevention/988-lifeline>

Preparing for 988, Frequently asked questions (FAQ)

Vibrant Emotional Health

Vibrant and 988

<https://www.vibrant.org/988/>

Frequently asked questions (FAQ), Documents for stakeholders, Vibrant statements on 988, Press releases and statements

National Suicide Prevention Lifeline (NSPL)

How Our Calls are Routed

<https://suicidepreventionlifeline.org/wp-content/uploads/2021/08/Back-to-Basics.png>.

The CEO Huddle

988: America's First 3-digit Mental Health Crisis Line

<https://www.thekennedyforum.org/988toolkit/>

988 toolkit and resources

CrisisNow

Embedding crisis response in Harris County's 911 dispatch center

<https://talk.crisisnow.com/embedding-crisis-response-in-harris-countys-911-dispatch-center/>

Los Angeles Department of Mental Health

<http://file.lacounty.gov/SDSInter/bos/supdocs/149282.pdf>

911 alternative crisis response protocols and decision trees

911 Distressed Caller Diversion Program Broome County, New York

<https://www.theiacp.org/sites/default/files/MHIDD/BroomeDiversion-508.pdf>

911 distressed caller distressed caller decision tree

The National Action Alliance for Suicide Prevention (Action Alliance)

988 Messaging Framework

<https://theactionalliance.org/task-force/988-messaging>

The National Action Alliance for Suicide Prevention (Action Alliance)

Framework for Successful Messaging

<https://suicidepreventionmessaging.org/>

Centers for Disease Control and Prevention (CDC)

Health Equity Guiding Principles for Inclusive Communication

https://www.cdc.gov/healthcommunication/Health_Equity.html

Vibrant Emotional Health

988 and the National Suicide Prevention Lifeline

https://www.vibrant.org/wp-content/uploads/2020/07/988_two_pager_2021-2.pdf

Frequently asked questions (FAQ) and overview

CrisisNow

988 Crisis Jam Learning Community

<https://talk.crisisnow.com/learningcommunity/>

Weekly about 988 and integrated crisis care calls with +60 behavioral health organizations

Section 5: Integrating equity into crisis systems

Substance Abuse and Mental Health Services Administration (SAMHSA)

National Guidelines for Behavioral Health Crisis Care

<https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

Crisis care best practice toolkit

The National Council

Roadmap to the Ideal Crisis System

https://www.thenationalcouncil.org/wp-content/uploads/2021/03/031221_GAP_Crisis-Report_ExecutiveSummary-final.pdf?dof=375ateTbd56

Local and Regional Government Alliance on Race and Equity (GARE)

Racial Equity Tools

<https://www.racialequityalliance.org/tools-resources/>

**Minnesota Center for Health Statistics – Minnesota Department of Health
HEDA: Conducting a Health Equity Data Analysis**

<https://www.health.state.mn.us/data/mchs/genstats/heda/healthequitydataguideV2.0-final.pdf>

A guide to assessing health equity within health systems

Section 6: Financial sustainability

**Substance Abuse and Mental Health Services Administration (SAMHSA)
Community Mental Health Services Block Grant (MHBG)**

<https://www.samhsa.gov/grants/block-grants/mhbg>

**Substance Abuse and Mental Health Services Administration (SAMHSA)
Substance Abuse and Treatment Block Grant (SABG)**

<https://www.samhsa.gov/grants/block-grants/sabg>

**Substance Abuse and Mental Health Services Administration (SAMHSA)
State Opioid Response Grant (SOR)**

<https://www.samhsa.gov/grants/grant-announcements/ti-20-012>

**Substance Abuse and Mental Health Services Administration (SAMHSA)
Tribal Opioid Response Grants (TOR)**

<https://www.samhsa.gov/grants/grant-announcements/ti-21-007>

**Substance Abuse and Mental Health Services Administration (SAMHSA)
Tribal Behavioral Health Grant Program (Native Connections)**

<https://www.samhsa.gov/grants/grant-announcements/SM-21-011>

**Substance Abuse and Mental Health Services Administration (SAMHSA)
Transformation Transfer Initiative (TTI)**

<https://www.nasmhpd.org/transformation-transfer-initiative->

**Substance Abuse and Mental Health Services Administration (SAMHSA)
FY 2022 Grant Announcements and Awards**

<https://www.samhsa.gov/grants/grant-announcements-2022>

Centers for Medicare & Medicaid (CMS)

**Medicaid Guidance on the Scope of and Payments for Qualifying Community-Based
Mobile Crisis Intervention Services**

<https://www.medicaid.gov/federal-policy-guidance/downloads/sho21008.pdf>

Technical Assistance Collaborative (TAC)

**Mobile Crisis Teams: A State Planning Guide for Medicaid-Financed Crisis Response
Services**

<https://www.tacinc.org/resource/state-planning-guide-for-medicaid-financed-mobile-crisis-response/>

Centers for Medicare & Medicaid (CMS)

100 percent FMAP for LTSS — Educate Your State

<https://www.cms.gov/Outreach-and-Education/American-Indian-Alaska-Native/AIAN/LTSS-TA-Center/info/100-percent-fmap-educate-your-state#:~:text=CMS%20reimburses%20each%20state%20for,typically%20have%20a%20higher%20FMAP.>

Overview of Medicaid services and matching for tribes

Section 7: Legislations and oversight

National Association of State Mental Health Program Directors (NASMHPD)

Model Bill for Core State Behavioral Health Crisis Services Systems

https://www.nasmhpd.org/sites/default/files/FINAL_988_Model_Bill_2-22-22_edited.pdf

National Association of State Mental Health Program Directors (NASMHPD)

Model Bill for Core State Behavioral Health Crisis Services Systems – slides

https://www.nasmhpd.org/sites/default/files/NASMHPD_988_Model_Bill_Slides.pdf

National Association of State Mental Health Program Directors (NASMHPD)

States' Experiences in Legislating 988 and Crisis Services Systems

https://www.nasmhpd.org/sites/default/files/2022_nasmhpd_StatesLegislating988_022922_1753.pdf

National Alliance on Mental Illness (NAMI)

NAMI 988 State Bill Tracking

<https://www.quorum.us/dashboard/external/mgWzdPqJLWHohzOhdRWE/>

988 bill tracker with map and links to 988-related legislation

National Alliance on Mental Illness (NAMI)

988 Crisis Response Advocates Workgroup

https://docs.google.com/forms/d/e/1FAIpQLSee0YIlxQQDXY-NAuKv2a7x9i-fWi_JUjSPpn6IjDS6hW2iGg/viewform

Sign-up sheet for monthly state policy and advocacy calls to discuss efforts and strategies to advance 988 and crisis services

Section 9: Data and performance management

Substance Abuse and Mental Health Services Administration (SAMHSA)

National Guidelines for Behavioral Health Crisis Care

<https://www.samhsa.gov/sites/default/files/national-guidelines-for-behavioral-health-crisis-care-02242020.pdf>

Crisis care best practice toolkit

National Suicide Prevention Lifeline (NSPL)

Crisis Call Center Metrics

https://suicidepreventionlifeline.org/wp-content/uploads/2019/02/CallCenterMetrics_final.pdf

**Arizona Health Care Cost Containment System (AHCCCS)
Contractor contract amendment**

https://www.azahcccs.gov/Resources/Downloads/ContractAmendments/RBHAs/RBHA_MAR_ICOPA_100121_AMD16_FINAL.pdf

Contract framework and details

**Arizona Health Care Cost Containment System (AHCCCS)
Medical Policy Manual**

<https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH20/AMPM590.pdf>

Contractor crisis services requirements

**Arizona Health Care Cost Containment System (AHCCCS)
Crisis Services Data Reporting template**

<https://www.azahcccs.gov/PlansProviders/Downloads/RFPInfo/YH20/AMPM590A.pdf>

Note:

In addition to the sources noted above, this document incorporates information shared during the States, Territories, and Tribes Working Group meetings of partners of the SAMHSA / NASMHPD 988 co-sponsorship (December 2021 – March 2022).