

Snapshot of Behavioral Health Crisis Services and Related Technical Assistance Needs Across the U.S. (Updated Version)

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FINAL

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Introduction

Treating and resolving behavioral health crises is one of the top priorities of any mental health system. Recently, the Substance Abuse and Mental Health Services Administration (SAMHSA) and states have invested tremendous effort and resources in both (1) establishing best practices for effective behavioral health crisis care systems and (2) creating the infrastructure for such systems to be accessible to everyone in the country, like other crisis systems (e.g., emergency medical services [EMS], law enforcement). The nationwide transition to the [988 Suicide & Crisis Lifeline](#) (Lifeline) in July 2022 was the culmination of this effort.

SAMHSA released its *National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit* (*National Guidelines*) in 2020. This toolkit specifies that crisis care systems in the United States require three primary components and two support services. In November 2022, the Department of Health and Human Services, through SAMHSA, released the *National Guidelines for Child and Youth Behavioral Health Crisis Care*, drawing attention to the urgent need to improve behavioral health crisis response services for children, youth, and their families. These guidelines also outline how communities can work to address existing gaps in the crisis system for youth. As these guidelines were released after the research was conducted for this report, they are not specifically addressed in this inventory and environmental scan.

The primary components of a behavioral health crisis care system are:

1. **Regional crisis call center** – *someone to call*: A contact centers, available 24/7 and staffed by trained counselors, that provides behavioral health crisis intervention via telephone, texting, and online chat. In addition, the center should provide real-time crisis care coordination through “air traffic control” technology (i.e., not just provide a referral, but ensure that a caller receives the care indicated by their situation).
2. **Mobile crisis team (MCT)** – *someone to respond*: Mobile crisis team services offering community-based intervention to individuals in need wherever they are; including at home, work, or anywhere else in the community where the person is experiencing a crisis. The composition of MCTs may vary by state, depending on the availability of an adequate workforce, as well as legislative requirements. SAMHSA recommends a mobile crisis team should utilize two providers per response (e.g., licensed counselors, social workers, physicians, EMTs, crisis workers, peers, etc.). If necessary, one provider can respond via telehealth. A person trained in crisis response may includes a peer or paraprofessional. Some state mobile crisis response programs include law enforcement or other first responders. MCTs may also incorporate telehealth technology into their services. When indicated, the team will provide a warm handoff to other treatment services (including in some states the MCT transporting a client to a crisis receiving and stabilization facility) as well as providing connections to other community resources, services and supports.
3. **Crisis receiving and stabilization services (CRSF)** – *a safe place to be*: Crisis receiving and stabilization services offer the community a no-wrong-door access to mental health and substance use care; operating much like a hospital emergency department that accepts all walk-ins, ambulance, fire, and police drop-offs. They need to say yes to mental health crisis referrals, including working with persons of varying ages (as allowed within the facility license) and clinical conditions regardless of the acuity of the person in crisis.

In addition to the primary components, support services to a crisis care system include, but are not limited to:

1. **Short-term residential facility:** A non-hospital alternative to inpatient care, for individuals experiencing crisis and who are assessed and determined to require medically monitored, residential or non-residential services. These facilities cannot accept all referrals but play an important role in a continuum of care.
2. **Peer-operated respite program:** Is also a short-term care facility and is run by peers. It provides access to a peaceful sanctuary for individuals after a crisis or seeking to avoid a crisis. Licensed clinicians may assist the peer staff but are not usually part of the staff.

Ideally, crisis services exist along a continuum according to the level of acuity of an individual's crisis. These range from warmlines, which seek to prevent a crisis, to inpatient mental health treatment, a more restrictive and intensive treatment modality. There are several primary entry points for this system: a call to a crisis hotline, interaction with law enforcement, admission to a medical facility (e.g., an emergency department [ED], or walk-in to a mental health provider (such as a Certified Community Behavioral Health Clinic (CCBHC) or a crisis respite center).

The expansion of the 988/Lifeline system has the ability to make the first entry point from the Lifeline increasingly efficient. Its trained counselors can coordinate next steps within the system for the individual experiencing crisis and dispatch an MCT (and/or law enforcement and/or EMS). The MCT can provide further treatment and a warm handoff to additional care as needed (e.g., crisis stabilization services, a short-term residential facility, a peer-operated respite facility, or ambulatory care). Ideally this method seeks to ensure that an individual experiencing crisis follows a path through the crisis care system that matches their level of crisis acuity and quickly leads to service.

SAMHSA's *National Guidelines for Behavioral Health Crisis Care*, as well as the *National Guidelines for Child and Youth Behavioral Health Crisis Care*, emphasize that the three primary components of a crisis care system and support services must collaborate closely with each other and with the larger community behavioral health (including mental health and substance use) and hospital systems, to form an integrated, coordinated system of care.

Crisis Intervention Team (CIT). One focus of crisis integration is to shift in-person crisis responses away from law enforcement to community-based MCTs. The *National Guidelines* support a system that decreases the use of law enforcement officers (LEOs) in the response to many behavioral health crisis calls. When LEOs must respond to a behavioral health crisis, such as due to imminent danger or lack of available MCTs, the CIT approach integrates appropriate crisis service into law enforcement operations by providing behavioral health training to LEOs and sometimes partnering them with behavioral health and social services workers. Clinicians, social workers, and peers may accompany LEOs on calls. Research indicates that LEOs often encounter people with mental illness and co-occurring conditions and transport people experiencing a mental health crisis to medical facilities, where they may spend a long time waiting for the person in crisis to be admitted. LEOs may instead transport a person experiencing a mental health crisis to a jail, which is an inappropriate and traumatizing setting for their behavioral health needs.¹

Service Registry. A second important component of crisis care system coordination is a bed/service registry, which many states are currently using or implementing, to ensure that individuals with behavioral health crises who need additional services can quickly receive these services. Ideally, a service registry serves as a type of air-traffic control system that tracks the real-time availability of all appropriate behavioral health services, including the availability of outpatient appointments for individuals needing ambulatory follow-up, available crisis receiving and stabilization facility slots as well as residential and inpatient beds (for both mental health and substance use services). Several states are implementing Crisis

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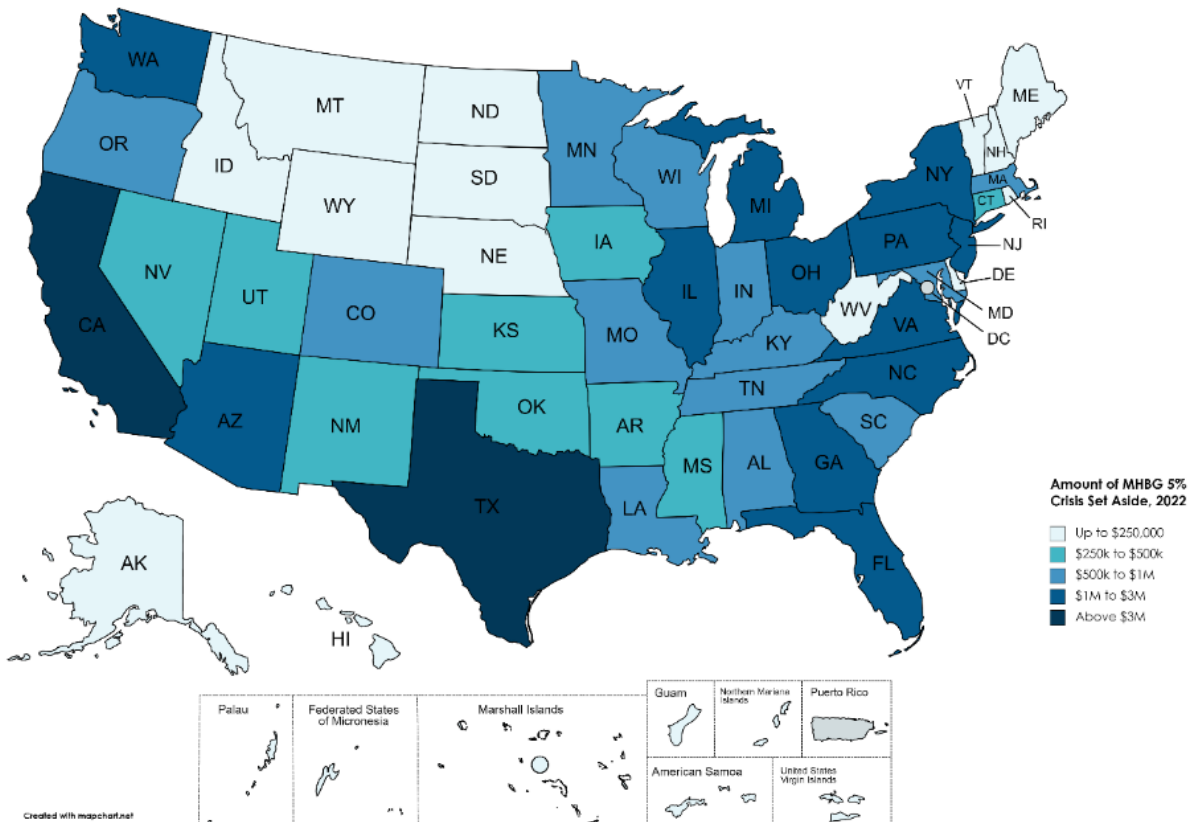
Service Registries that not only track available services, but that permit making appointments or transmitting referral materials to reserve an appropriate treatment bed. Two major challenges for states and communities have been to ensure that the information about available services or beds is up to date and to involve the participation of all public and private behavioral health treatment providers in their region. While some registries focus only on tracking psychiatric beds, increasingly states are seeing these registries as a way to identify the most appropriate level of service and help the individual in crisis receive that service.

Community Mental Health Block Grant Set Aside for Crisis Systems

In 2021, Congress directed SAMHSA to specify that states, territories, and the District of Columbia (“states”) set aside five percent of their community mental health block grant (MHBG) funds for evidence-based crisis systems for adults exhibiting signs of severe mental illness (SMI) and children exhibiting signs of serious emotional disturbances (SED).² This set-aside provided over \$40 million of additional funding for crisis services³ and was made permanent in the Consolidated Appropriations Act, 2023⁴. Every state now has funding available to develop a robust continuum of crisis services, including (but not limited to) crisis call centers, MCTs, and short-term crisis stabilization services for both adults and youth.

Given the variation in the amount of MHBG funds awarded to each state (see Figure 1), the crisis services set-aside provides more funding to some states than to others. Due to the U.S. territories and Pacific Jurisdictions receiving lower MHBG allocations than most states, the five percent set-aside may not be enough to fund their 24/7 call centers or mobile crisis teams. The ability to use local tax funds and to bill Medicaid, Medicare, and private insurance remains critical for a sustainable crisis care system.

Figure 1: 2022 MHBG 5% Set-Aside for Crisis Services, Amount by State⁵



Launch of the 988/Lifeline

In 2020, Congress designated 988 as the national dialing code for behavioral health crisis as an easy-to-remember alternative to a 10-digit phone number.⁶ The nation transitioned to the 988/Lifeline system in July 2022. Formerly known as the National Suicide Prevention Lifeline, the Lifeline provides an easy to remember alternative to 911 for someone in crisis to access behavioral health crisis services by connecting those that call the contact center to a trained expert. Additionally, 988 staff can help to connect individuals to the most appropriate community resources. The Lifeline now operates in all states, the District of Columbia, and several of the U.S. territories. Table 1 compares the number and mode of contacts to the Lifeline and the nature of responses to them before 988 went into effect in June 2022 to those in August 2022, which was the first full month of operation for that system. During August, contacts increased 30 percent over June, and the rate of abandoned calls decreased from 20 percent to 12 percent.

Table 1: Change in Contacts Before and After the Launch of 988⁷

	June 2022				August 2022				Change			
	Calls	Chats	Texts	Total	Calls	Chats	Texts	Total	Calls	Chats	Texts	Total
Routed	184,819	85,263	7,335	277,407	256,398	64,115	40,627	361,140	38.7%	-24.8%	453.9%	30.2%
Answered	83%	72%	96%	80%	84%	97%	98%	88%	1%	25%	2%	8%
Abandoned	17%	28%	4%	20%	16%	3%	2%	12%				

Non-Lifeline call centers, however, still serve significant numbers of people. Twenty-six states that already operated crisis call centers before the transition to the Lifeline are continuing to support these call centers. In these states, many behavioral health clients are accustomed to contacting their local crisis center (using a local 10-digit or three-digit number, such as 211) and the states are maintaining these numbers to ensure continuing access to crisis services. This paper presents data on both categories of call centers.

Methodology

Data and information used to compile this report are derived from a variety of sources, including NRI’s [State Profiling System](#), 2022/2023 state mental health authority (SMHA) MHBG applications accessed via SAMHSA’s [Web Block Grant Application System \(WebBGAS\)](#), SMHA American Rescue Plan Act of 2021 (ARPA) Supplemental Funding Plans, and SMHA COVID-19 Relief Plans. As such, unless stated otherwise (i.e., additional resources accessed during November 2022 are referenced throughout, where applicable), all statistics, figures, etc. come from these sources. A brief description of NRI’s State Profiling System and the MHBG applications are below.

NRI State Profiling System

The NRI State Profiling System consists of data derived from a series of surveys that collect detailed information about SMHAs organizations and structures, service systems, eligible populations, emergency policies and service issues, fiscal resources and structure, consumers served, and additional timely and relevant topics (e.g., behavioral health workforce). NRI develops the Profiles surveys under the guidance of an advisory group comprising SMHA Commissioners and State MHBG Planners, as well as program staff, National Association of State Mental Health Program Directors (NASMHPD), and NRI staff. Each year, NRI sends the profile surveys to the SMHA Commissioners, who designate contacts to complete and return the surveys to NRI. Select State Profiles reports are publicly available online at <https://www.nri-inc.org/profiles>.

For the 2022 Profiles, NRI worked with NASMHPD and SMHA crisis service coordinators to design and conduct one survey to establish the current status of crisis services supported by state systems and another survey focused on the financing of crisis systems. The crisis services survey was sent to 50 states and the District of Columbia during the summer of 2022 and 48 SMHAs responded. Forty-one SMHAs responded to the finance survey (note: the same SMHAs may not have responded to both). The NRI survey used the definitions contained in the *SAMHSA National Guidelines for Behavioral Health Crisis* for call centers, mobile crisis teams, and crisis receiving and stabilization facilities to guide state reporting. The survey collected information about the models/composition of mobile crisis teams by state and the model and organization of crisis receiving and stabilization facilities. States can vary widely in exactly how they operationalize these types of crisis services, but for the purpose of reporting results, any program a state identifies as a MCT is reported as a MCT and any program identified as a CRSF is reported as CRSF (even if the state's version of that service differs from the definition in the SAMHSA National Guidelines).

The crisis survey focused on the three primary components of the crisis care system highlighted by SAMHSA's *National Guidelines* and also gathered information about short-term crisis residential facilities, behavioral health emergency department (ED) initiatives, and coordination with law enforcement, including the coordination between 911 and 988 call centers.

MHBG Applications on WebBGAS

To determine SMHAs' technical assistance (TA) needs related to crisis services, NRI examined each SMHA's 2022/2023 MHBG application on WebBGAS. During October 2022, NRI staff reviewed Section 15: Crisis Services of each of the 59 states and territories' 2022/2023 applications to identify any training and technical assistance (T/TA) needs related to implementing services within the crisis continuum. Based on this review, NRI staff identified 11 states with TA requests made through their MHBG applications. NRI staff also reviewed this section of the MHBG applications to identify efforts specific to special populations (e.g., Lesbian, Gay, Bisexual, Transgender, Queer, and Intersex (LGBTQI+), racially and ethnically diverse communities, older adults, children and youth, Native Americans and Alaska Natives, and individuals living in rural and remote communities), SMHAs' use of technology, relationships with recovery coaches and recovery organizations, the inclusion of psychiatric advance directives and wellness recovery action plans in crisis prevention, and other crisis-focused efforts. Findings are addressed later in this report.

ARPA Supplemental Funding Plans

The American Rescue Plan Act (ARPA) of 2021 allocated additional funds through the Mental Health and Substance Use Block Grants to address the impacts of the COVID-19 pandemic on individuals with mental health and substance use disorders. States were required to submit their plans for using the ARPA funds to SAMHSA. SAMHSA encouraged states to focus their plans on activities that would support the behavioral health crisis continuum. Plans from each state were reviewed by NRI and NASMHPD staff in January 2023 for efforts related to the expansion and improvement of states' crisis continuums. Findings are addressed later in this report.

COVID-19 Relief Funding Plans

To help states address challenges brought on by the COVID-19 pandemic, HHS awarded emergency grants and cooperative agreements under the Coronavirus Aid, Relief, and Economic Security (CARES) Act. States were required to submit their plans for using the COVID-19 supplemental funds to SAMHSA.

Plans from each state were reviewed by NRI and NASMHPD staff in January 2023. Information about how states proposed to use the funds are included in this report.

Other Resources

In addition to reviewing the NRI State Profiling System and the MHBG applications, researchers identified other T/TA needs related to crisis services through participation in regular calls with NASMHPD and the SMHA Commissioners. States undertaking unique and innovative approaches to the delivery of crisis services were also identified through these calls, as well as through NRI and NASMHPD's work on [SMI Adviser](#) with the American Psychiatric Association and SAMHSA. Researchers also acquired information from Vibrant Emotional Health, the national Lifeline Administrator, and other national behavioral health crisis service leaders' websites. As stated above, these additional resources are referenced when included in the text.

State of the States

According to NRI's 2022 State Profiles,⁸ of the 48 responding SMHAs, all offer at least one of the crisis services recommended in SAMHSA's *National Guidelines*. Of those:⁹

- 100 percent fund or operate Lifeline call centers.
- 65 percent fund or operate other 24/7 crisis hotlines.
- 92 percent fund or operate mobile crisis response.
- 67 percent fund or operate less-than-24-hour crisis stabilization units (CSUs).
- 77 percent fund or operate crisis residential programs (CRPs) (more-than-24-hour programs).

In addition:¹⁰

- 52 percent of all responding states embed behavioral health clinicians in EDs.
- 82 percent of SMHAs work with or train law enforcement to provide CIT.
- 63 percent fund or operate crisis respite programs.

It is important to note that the U.S. territories are also working to implement 988 across their jurisdictions. American Samoa, Guam, the Commonwealth of the Northern Mariana Islands, Puerto Rico, and the Virgin Islands are all leveraging cooperative agreements from SAMHSA to build local Lifeline capacity.¹¹ The U.S. territories, however, especially the Pacific jurisdictions, face unique challenges, including a small population often spread across multiple islands and a limited provider workforce, which create obstacles for the provision of MCTs and the implementation of CSUs.¹²

Tribal organizations are also working to implement the Lifeline. Native and Strong in Washington state is a dedicated lifeline center. The Lifeline presents an opportunity for other state and tribal partners to come together.

Crisis Call Centers: Hotlines, Warmlines, and 988

As of April 2023, every state operates at least one Lifeline call center, and more than 200 Lifeline call centers are providing services.¹³ In addition, as of the summer of 2022, 15 states are planning to open at least 18 additional Lifeline call centers, and many other states are working to expand the capacity of their existing call centers.¹⁴ Of the Pacific Jurisdictions, American Samoa and Guam operate 988/Lifeline call centers. The others are working on options to establish them. Due to a lack of reporting responses, the subsequent data will focus on the states.

In addition to the Lifeline call centers, many states continue to fund and support the operation of additional call centers and peer-operated warmlines. In 2022, 31 states reported supporting the operation of 344 additional call centers, which handled nearly 1.78 million crisis calls.¹⁵ Non-988 crisis call centers are primarily operated by community mental health providers (18 states), followed by Managed Care Organizations (MCOs; 6 states), Certified Community Behavioral Health Clinics (CCBHCs; 5 states), and directly by the SMHAs (2 states).¹⁶ Most of these independent call centers will continue to operate outside of the Lifeline network (20 states reporting).¹⁷

States report that while Lifeline and other crisis call centers handle millions of calls each year, major challenges remain to ensuring their operation 24/7.¹⁸

- Twenty-nine (29) states report that staffing call centers is a major challenge, especially for second, third, and weekend shifts.
- The second largest challenge is having adequate capacity to meet increased demand without requiring activation from backup centers to answer incoming calls.
- Thirdly is sustainable financing for call centers.
 - Current funding for Lifeline call centers and other call centers comes from federal 988 implementation funds (48 states), MHBG crisis set-aside funds (24 states), and state general funds (34 states).
 - Only seven (7) states, however, report support for call centers via Medicaid reimbursement.
 - Only a few states have passed telephone fees (discussed later) to sustain ongoing call center operations.
 - Some states also use a limited pool of private funds to supplement service. For example there are centers that leverage 211 counselors funded through the United Way to respond to 988 contacts.

Additionally, states are struggling to establish rules to coordinate calls between 911 public safety answering points (PSAPs) and Lifeline call centers. Only nine states reported having current agreements with 911 systems about when to divert calls to or from crisis call centers. Most states reported a need for developing decision trees and operational rules between the two systems.¹⁹ The challenge establishing these relationships may be due to the fact that many PSAPs are operated locally and more than one PSAP can exist per area code. Therefore, states will need to develop relationships with multiple local PSAPs instead of having one state-wide set of 911 and 988 decision rules. See Appendix A for examples of 911 decision trees that may be modified to help 911 and 988 systems better collaborate to appropriately direct calls.

Another method to improve the relationship between 911 and 988 crisis call centers is to physically embed crisis call centers into 911 facilities. The Harris Center for Mental Health and IDD (intellectual or developmental disabilities) in Houston, Texas, began implementing this model in 2015 to reduce the unnecessary burden on LEOs of responding to behavioral health crises and to provide more appropriate, proactive care to individuals in need. Behavioral health call takers undergo rigorous training to encourage confidence in the program and with the emergency communications team. Call takers are required to have, at minimum, a bachelor's degree in psychology, sociology, or a related field and receive training on CIT, cultural awareness and trauma-informed care, rapport building and empathetic listening, privacy and confidentiality, assessing for suicidal and homicidal ideation, safety planning and de-escalation, and mandatory reporting scenarios. Between June 2017 and March 2021, the program diverted more than 3,000 calls from fire department response, and 7,500 calls from law enforcement response, saving more than \$6.5 million across the 2 departments over the 4 years.

Source: Neylon, K. (2021, December 14). Embedding crisis response in Harris County's 911 dispatch center. #CrisisTalk. <https://talk.crisisnow.com/embedding-crisis-response-in-harris-countys-911-dispatch-center/>

Organizations across the country are also making accommodations to ensure that services are accessible and equitable for special populations. There are crisis lines that specialize in serving LGBTQI+, native Spanish speakers and more. Another example of this is DeafLEAD's (Leadership, Esteem, Ability, Discipline) 24-hour crisis hotline and texting services that ensure crisis services are available to all individuals who are D/deaf, DeafBlind, hard of hearing, late-deafened, and hearing.

Mobile Crisis Team Response

Forty-four of the 48 responding states reported either currently supporting MCTs or working to establish teams in 2023.²⁰

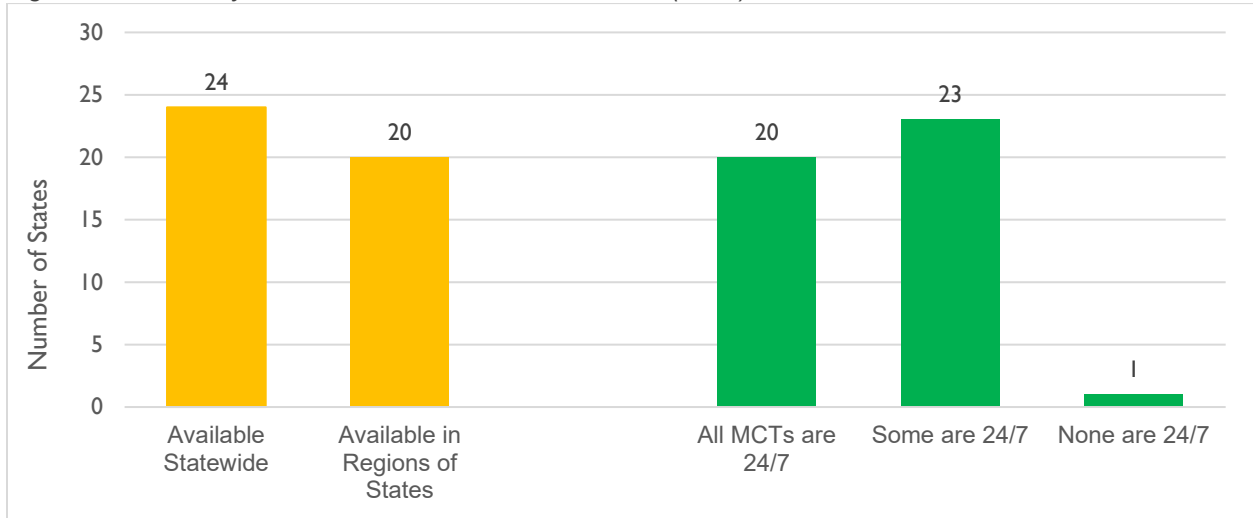
- Forty-four (44) states reported a total of 1,287 MCTs, including 110 mobile child/adolescent-dedicated crisis teams in 15 states.
- Thirty-one (31) states reported plans to open at least 173 additional MCTs during the year.
- In 2021, MCTs across 28 states served 512,305 individuals experiencing a behavioral health crisis.
- Regarding operation of MCTs:
 - In 35 states, community mental health providers operate MCTs.
 - In 15 states, CCBHCs operate them.
 - In seven states, the SMHA itself operates the MCTs, while MCOs have established MCTs in four states.
 - Ten (10) states use other organizational arrangements to operate these services, including combinations of the previously listed organizations.

Although states are supporting MCTs, many states report that these services are not yet available statewide. It is especially challenging to implement MCTs in rural and remote areas, and it is also difficult

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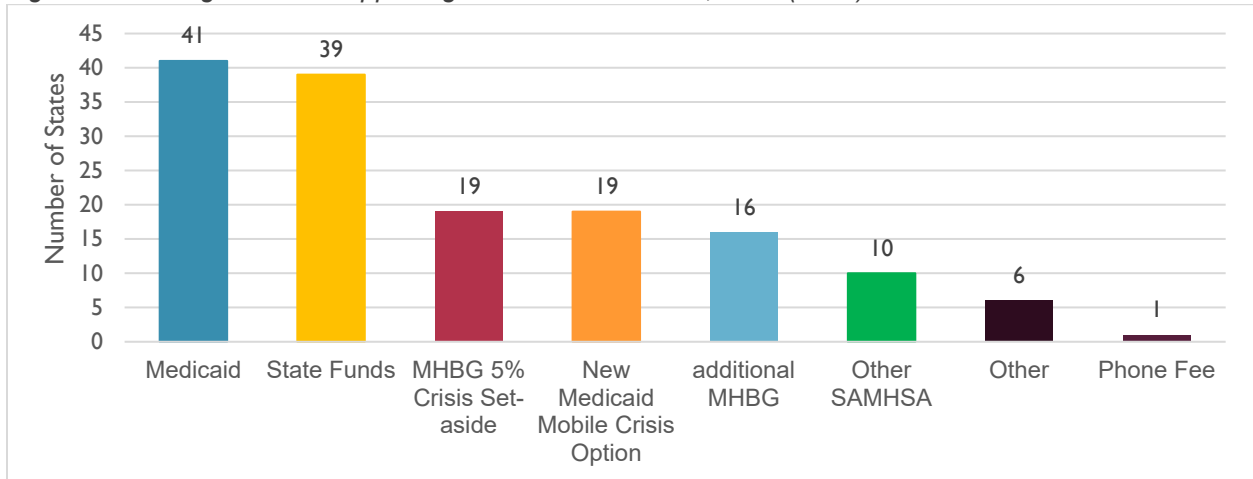
to secure sufficient staffing to maintain operation 24/7. Figure 2 shows that only 24 states report that MCTs are available statewide, and even fewer (20 states) have MCTs that can respond to individuals in crisis 24/7.

Figure 2: Availability of MCTs Statewide and 24/7, 2022 (n=42)²¹



As Figure 3 illustrates, states are supporting MCTs using funding from a variety of sources, with Medicaid, state general funds, and the SAMHSA MHBG 5 percent crisis set-aside the most frequent funding sources leveraged by states.

Figure 3: Funding Sources Supporting Mobile Crisis Teams, 2022 (n=42)²²



A third of the responding SMHAs are monitoring outcomes related to MCTs.²³ Of MCT dispatches:

- 46 percent end with an outpatient behavioral health appointment being made (15 states responding).
- 12 percent end with an individual transferring to a CSU for additional care (15 states responding).
- 14 percent end with an individual going to an ED (15 states responding).
- 37 percent end with an individual being referred to outpatient behavioral health services (16 states responding).

Less-than-24-Hour Crisis Stabilization Units²⁴

Thirty-four (34) states report a total of 237 crisis stabilization programs, including 21 programs across seven states that specialize in serving children and adolescents. Twenty-one (21) states reported plans to open 139 additional CSUs in the next year. In 19 states CSUs, although designed to provide short-term, less-than-24-hour care, are permitted to continue to serve individuals in crisis beyond 24 hours if additional time is needed. Thirteen (13) states require CSUs to maintain less-than-24-hour treatment.

Regarding operation:²⁵

- Community mental health providers operate CSUs in 27 states
- CCBHCs operate them in eight (8) states.
- SMHAs operate CSUs in four (4) states.
- MCOs operate them in two (2) states.
- Nine (9) states describe alternative organizations operating CSUs. Many of them report a combination of organizations supporting CSUs.

Assuring these programs are available statewide and 24/7 is a major challenge for nearly all states. Only eight of the responding states report CSUs available statewide. Those available facilities, however, tend to be in operation 24/7; only four states reported that their CSUs are not open 24/7. States describe continuing challenges hiring and maintaining a workforce to keep these facilities open 24/7. Major barriers to operating CSUs statewide, 24/7 include:²⁶

- Workforce (24 states)
- Financing (9 states)
- Issues related to operating the programs in rural and remote areas (4 states).

Another issue commonly cited by states is insufficient information regarding available beds or outpatient behavioral health services, which complicates making referrals for clients leaving CSUs.²⁷

Twenty-seven percent of states are collecting outcomes data about CSUs.²⁸ Nine (9) states report receiving data about the disposition of CSU-served individuals.²⁹

- Seven states indicate that an average of 51 percent of clients have their immediate crisis resolved at the CSUs.
- 73 percent of clients are discharged from a CSU with a referral or follow-up outpatient services (five states responding).
- Only five (5) percent of clients are transferred to an ED (eight states responding).
- Thirteen (13) percent of clients require further care at a psychiatric hospital or substance use disorder withdrawal management facility (seven states responding).

Short-Term Crisis Residential Programs

CRPs are a resource for individuals who need continually monitored care but do not require more intensive psychiatric inpatient or substance use disorder withdrawal management treatment. Thirty-seven (37) states support short-term CRPs, which together served 118,383 individuals in the prior year. Of those states with figures available:³⁰

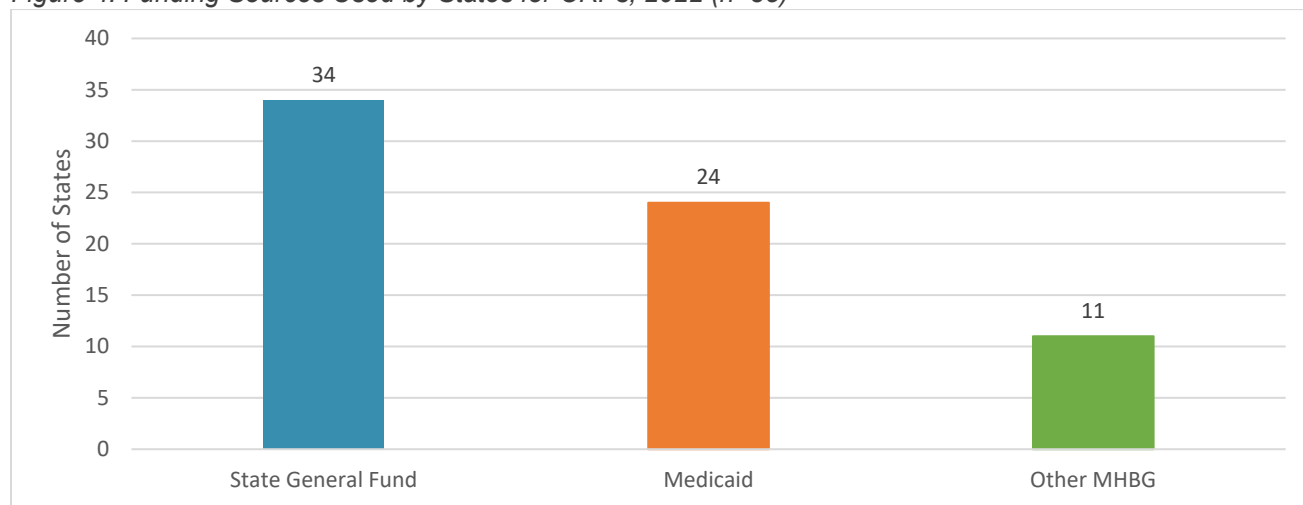
- 516 CRPs are currently serving behavioral health clients in 37 states.
- 26 states are working to open 100 additional programs.
- In 14 states, CRPs are available statewide. In 27 states, they are available only in parts of a state.

Regarding operation:³¹:

- Community mental health providers operate CRPs in 35 states.
- CCBHCs operate them in 11 states.
- SMHAs operate them directly in five states.
- MCOs operate CRPs in two states.
- A variety of other organizational types operate them in 10 states.

As Figure 4 shows, CRPs are funded by state general funds in 30 states, by Medicaid in 21 states, and by MHBGs in 11 states. (Note: Due to the [Medicaid IMD \(Institutions for Mental Disease\) Rule](#), CRPs with more than 16 beds may be ineligible for MHBG funding or Medicaid reimbursement if they serve adults ages 21 through 64).

Figure 4: Funding Sources Used by States for CRPs, 2022 (n=35)³²



Barriers to expanding crisis residential services include insufficient workforce (24 states), followed by insufficient bed capacity (9 states) and sustainable funding (8 states).

Psychiatric Emergency Departments

Initiatives to provide behavioral health expertise to hospital EDs are ongoing in 25 states. These initiatives include funding mental health experts to work in EDs or with hospitals to establish dedicated spaces with trained staff to address behavioral health crises. For example, one state responded in the 2022 state profiles that “some hospitals have created separate spaces with specialized staff to address psychiatric emergencies in the ED.”³³

Crisis Intervention Teams

The CIT approach trains LEOs on how to (1) work as a team to identify and safely support the immediate needs of individuals with behavioral health conditions (2) divert individuals from incarceration. Its objectives are to:

- Decrease the risk of harm to individuals in crisis
- Promote decriminalizing individuals with a mental illness
- Lessen the stigma associated with mental illness
- Reduce injuries to LEOs

As an example, Montana includes CIT training as part of its law enforcement academy and makes the training available throughout an LEO's career. The state has found that incorporating CIT has helped to shift the culture in the state surrounding law enforcement's response to mental illness. The training in Montana has evolved over time to incorporate peer-to-peer training, in which LEOs train other LEOs on how to best address mental health issues.

Source: Ezekiel, N., Malik, C., Neylon, K., Gordon, S., Lutterman, T., & Sims, B. (2021, August). Improving behavioral health services for individuals with SMI in rural and remote communities. Washington, D.C., American Psychiatric Association for SAMHSA, p. 51.

In the 2022 State Profiles,³⁴ 37 SMHAs report working with law enforcement agencies to provide CIT training. In 26 states, SMHAs provide some of the funding to support this training.

Alternative Transportation for Individuals Experiencing a Behavioral Health Crisis

Historically, individuals experiencing a behavioral health crisis are transported to EDs, hospitals, or CSUs by law enforcement in marked police cars and often require those transported to be restrained, usually with handcuffs. Requiring transportation for behavioral health services by LEOs can be very stigmatizing and traumatizing to the individual in crisis and burdensome to law enforcement by taking them away from other duties.

According to the 2022 state profiles:³⁵

- In 30 states MCTs can transport clients for additional crisis services (although in some states MCT can only transport voluntary individuals and LEO must transport individuals for involuntary care).
- Twelve (12) states have developed alternatives for transportation of individuals in crisis, and 12 others are working to change policies and/or laws that require law enforcement or EMS to conduct transport.
- In 24 states, rules still require LEOs to transport individuals to CSUs, EDs, or psychiatric hospitals.
- In nine states, when LEOs transport clients, rules require the individual to be restrained during transport.
- In 22 states, EMS services can transport clients; however, in four states, EMS are required to transport individuals to EDs and are not permitted to transport to CSUs.

San Luis Valley Behavioral Health Group in Colorado has developed a unique program to provide secure, comfortable, recovery-oriented transport to individuals to appropriate care. In 2017, this community provider in a remote part of the state piloted a program, through funding from the SMHA and Beacon Health Options (a Medicaid administrative services organization), to make a fleet of vehicles safe for specially trained drivers to transport individuals in crisis to care. The provider contracts with a private security company that employs former LEOs to serve as drivers, with each transport including two drivers for safety. The agency retrofitted two Ford Explorers with Plexiglass to create a secure area in the back of the vehicle, along with cameras to further ensure the safety of both the drivers and the passenger. All drivers are trained in CPR and Mental Health First Aid and given additional training on how to build rapport with their clients. Each vehicle also provides snacks and cold drinks for riders to consume, as well as blankets for added comfort

Source: Ezekiel, N., Malik, C., Neylon, K., Gordon, S., Lutterman, T., & Sims, B. (2021, August). Improving behavioral health services for individuals with SMI in rural and remote communities. Washington, D.C., American Psychiatric Association for SAMHSA, p. 18-19.

Using Technology to Provide and Enhance the Delivery of Behavioral Health Crisis Services

Many technologies exist to facilitate and enhance the delivery of crisis services, particularly for connecting with a crisis counselor and for mobile crisis response. Although it is unknown exactly how many states are leveraging technology to provide these services, several model examples are available, including an iPad program in Oklahoma (discussed below) and the use of telehealth for mobile crisis in South Carolina.³⁶

Oklahoma: GRAND Mental Health (GRAND) Tablet Program

Oklahoma has large regions of the state that have low density population, requiring MCTs to respond over great distances. GRAND is a CCBHC in northern Oklahoma that operates 22 behavioral health clinics across 12 counties, covering an area of more than 10,000 square miles. In 2016, the Oklahoma SMHA incentivized providers to develop alternatives to inpatient care that reduce hospitalization rates across the state. These alternatives enable community-based providers to use funds that would normally support hospitalization. GRAND opted to reallocate these funds to enhance crisis services across its large catchment area.

As part of this effort, GRAND began distributing iPads at the time of discharge to all recipients of crisis services at their facilities. The tablets support only one application (to conform with Medicaid rules and to discourage theft of the devices) and are set up to enable individuals to immediately connect to qualified staff, 24/7, at GRAND's centrally located intensive outpatient center. GRAND has also expanded the program to provide tablets for LEOs and EDs in the region.

In its first year of operation, GRAND distributed nearly 500 iPads to individuals, local law enforcement, and local EDs. LEOs within the catchment area have tablets that enable them to (1) immediately connect with mental health services providers to help triage crisis situations in the field, thereby reducing the need

for officers to transport individuals in crisis, and (2) connect directly with a clinician specialized in serving LEOs who experience their own crises related to traumas they faced in the field. While few officers have taken advantage of the officer-specific services, the existence of the service has helped to improve relations between the mental health provider and the law enforcement community across the state.³⁷

After implementing the program, inpatient hospitalization for adults within the GRAND catchment area decreased more than 93 percent between 2015 and 2021. Cost savings realized from reduced inpatient hospitalizations since the inception of the program total an estimated \$62 million. The implementation of this program also enabled LEOs to save time and mileage. In January 2022 alone, officers across the catchment area reduced time transporting clients by nearly 830,000 minutes.³⁸

Based on the success of this program, Oklahoma used federal stimulus funds to purchase iPads for every law enforcement vehicle in the state. Each iPad has an app on the home page that connects the LEO to the closest regional CCBHC crisis center. Each of the CCBHCs in Oklahoma now has a staffed team of crisis workers, who are available 24/7 to answer iPad crisis calls. When a LEO responds to a call from an individual experiencing a behavioral health crisis, they use the iPad app to connect to the regional crisis team and then hand the iPad to the individual in crisis.

Other Tablet Programs

New Mexico is currently replicating the use of iPads to augment mobile crisis response, and other states are examining the potential use of this type of technology to enhance crisis response in rural and remote areas.

Ensuring Crisis Care Across the Continuum

It is vital that the three critical components of a crisis service continuum recommended by the *National Guidelines* coordinate to ensure that individuals in need do not “fall through the cracks,” especially as more individuals engage with the behavioral health system through the Lifeline. To facilitate this coordination, states and providers will need to find a way to work together and with Lifeline call centers to collect data, monitor outcomes, and implement continuous quality improvement plans. Several states, including Georgia, Arizona, and Tennessee, have implemented strategies to better coordinate care across the crisis continuum.

Georgia. The [Georgia Crisis and Access Line \(GCAL\)](#) is an exemplary model for how components of the crisis continuum can work together to provide seamless crisis care. According to the state’s MHBG application, GCAL was implemented in 2006, when the Department of Behavioral Health and Developmental Disabilities (DBHDD) made the decision to centralize multiple call centers into one. Callers can now access the crisis hotline through call, text, or chat through 988, a 1-800 number, or through the My GCAL app. GCAL offers triage services and referrals to outpatient and specialty providers, serves as the single point-of-dispatch for MCTs, and manages the live referral and beds inventory for the state’s crisis stabilization program. This one point-of-contact enables the system to ensure that individuals move seamlessly through services as needed. DBHDD also relies on data to monitor how well its system is working, receiving crisis services data on a daily, weekly, monthly, and quarterly basis. These data are used to generate reports and to populate internal dashboards that are used to ensure system effectiveness and accountability.³⁹

Arizona. [Arizona's crisis system](#) is also identified as an exemplary program because its 24/7 crisis hotline which is able to respond to individuals in need telephonically and to dispatch MCTs across the state.⁴⁰

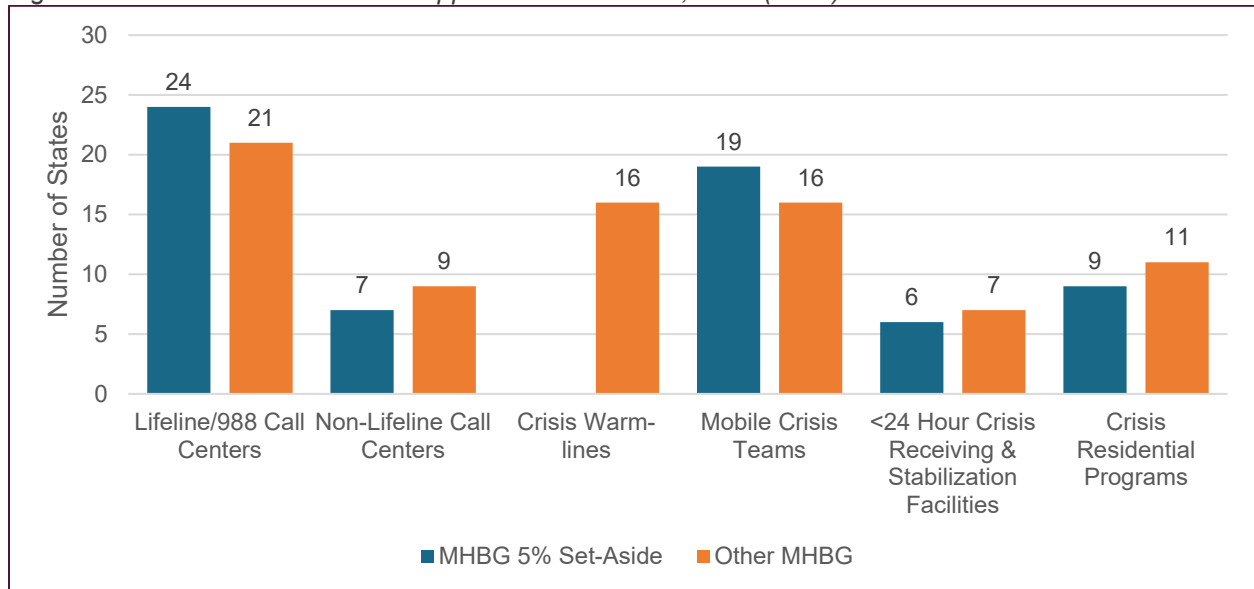
MCTs are available 24/7, statewide, and are “staffed by behavioral health professionals who travel to the individual experiencing a crisis, provide assessment and stabilization, and if needed, triage the individual to a higher level of care,” which may include transfer to a facility-based crisis stabilization unit.⁴¹ The crisis services offered in Arizona are able to serve any individual, regardless of insurance coverage.

Tennessee. In 2021, the [Tennessee Department of Mental Health and Substance Abuse Services](#) (TDMHSAS) implemented a comprehensive data monitoring system in response to providers expressing areas of need within the crisis continuum. This enabled TDMHSAS to thoroughly examine the data it did collect to see if it could identify gaps in the crisis system. It was determined that the data monitoring system currently in place could not identify gaps in the crisis system. Strong leadership from the SMHA Commissioner enabled TDMHSAS to significantly enhance its crisis management data system. To do this, the SMHA brought together a variety of stakeholders representing various groups and expertise, including information technology, hospitals, SMHA staff, TennCare (Medicaid), and providers. This enhanced data system, which can be publicly viewed on the [Tennessee Open Data Portal](#), also enabled the state to better align crisis services across agencies and providers.⁴²

Financing Crisis Services

As discussed earlier, in 2021, Congress appropriated over \$41 million of additional funds to the MHBG as a new 5 percent set-aside dedicated for crisis services. SAMHSA distributed these funds to states with guidance to use these funds to plan for and implement the continuum of crisis services from the *National Guidelines*. These new set-aside funds provide states with flexible funds dedicated to crisis services, and states report using them to support the components of their crisis system with the greatest need. As Figure 5 details, in 24 states, the SMHAs dedicated the set-aside funds to support Lifeline call centers, while other states used funds for MCTs, CSUs, or other aspects of their crisis continuum. In addition to using the new 5 percent set-aside funds, many states report devoting additional MHBG funds beyond the set-aside to support portions of their crisis continuum.

Figure 5: Use of MHBG Funds to Support Crisis Services, 2022 (n=41)⁴³



State general funds and the MHBG are the most frequently cited funding sources for all behavioral health crisis services. Although the MHBG stipulates that states spend at least 5 percent of their MHBG on crisis

Snapshot of Behavioral Health Crisis Services and Related Technical Assistance Needs Across the U.S.

services, the states indicate they are spending more than 5 percent of their MHBG funds on crisis services.

States identified Medicaid as another significant funding source for financing crisis services; however, they use Medicaid primarily to support face-to-face crisis services through MCTs, CSUs, and CRPs. Only a few states use Medicaid to support crisis call centers (either Lifeline or other behavioral health call centers). Many states also use other SAMHSA funding, including 988 funding.

As of March 2023, five states have passed legislation for a telephone tax (phone fee) to support behavioral health crisis services, as Table 2 shows. For example, phone fees in Virginia are limited to paying for Lifeline call center operations, whereas in Washington (State), they support the call centers, as well as MCTs, CSUs, and technology platforms for call centers and the crisis service delivery system.

Table 2: Number of States Using Specific Funding Sources to Support Behavioral Health Crisis Services, 2022, (n=42)⁴⁴

Funding Source	Lifeline	Non-Lifeline Call Centers	Mobile Crisis Teams	<24-Hour Crisis Stabilization	Crisis Residential Programs
State General Funds	34	20	39	29	34
MHBG 5% Set-Aside	24	7	19	6	9
Other MHBG Funds	21	9	16	7	11
Other SAMHSA Funds	30	7	10	3	4
Medicaid	7	8	31	24	24
New Medicaid MCT Option	N/A	N/A	119	N/A	N/A
Cell/Phone Fees ⁴⁵	5	0	3	1	0
Other Funding Sources	17	11	6	11	8

In 2022, as shown in Table 3, 42 states reported expending more than \$1.5 billion to support their behavioral health crisis service continuums, with most funds allocated toward Crisis Residential Programs (more than \$455 million). This is a significant underestimate as only 42 states were able to report expenditure data for crisis services.

Table 3: State Behavioral Health Agency Expenditures for Crisis Services, 2022 (n=42 states)⁴⁶

State Spending on Crisis Services	Total	Average Per State	Number of States Reporting	Number of Programs/Centers (Across All States)	Average Per Program/Center*
Lifeline Call Centers	\$310,901,176	\$7,582,956	41	185	\$1,839,652
Non-Lifeline Call Centers	\$75,328,499	\$5,021,900	15	344	\$706,892
Mobile Crisis Teams	\$405,360,818	\$16,214,433	25	1,287	\$535,201
<24-Hour Crisis Stabilization	\$307,915,440	\$13,996,156	22	237	\$2,070,830
Crisis Residential Programs	\$455,809,253	\$19,817,794	23	407	\$1,673,611

Snapshot of Behavioral Health Crisis Services and Related Technical Assistance Needs Across the U.S.

State Spending on Crisis Services	Total	Average Per State	Number of States Reporting	Number of Programs/Centers (Across All States)	Average Per Program/Center*
Total:	\$1,555,315,186	\$37,031,314	42	2,460	---

*Note: not all states reporting the number of crisis programs were able to report expenditures for crisis services. Average Expenditures per Program is calculated based on expenditures of reporting states divided by the number of programs in each state reporting expenditure data.

Barriers to Statewide, 24/7 Availability of Crisis Services and Related Technical Assistance Needs

All responding states are working to implement a robust behavioral health crisis services continuum, however, common barriers emerged when implementing 24/7 statewide crisis services.

Across call centers, MCTs, and CSUs, workforce and financing are the most frequent barriers identified by states, followed by the challenges related to providing crisis services in rural and remote parts of the state. Table 4 lists the types of barriers cited by states, along with which crisis services the barriers affect.

Table 4: Barriers to Statewide, 24/7 Implementation of Crisis Services, 2022 (n=42 states)⁴⁷

Barrier to Statewide, 24/7 Access	All Call Centers	Mobile Crisis Teams	<24-Hour Crisis Stabilization
Workforce	29	34	35
Financing	8	11	9
Rural/Remote	2	20	4
24/7 Operation and Staffing	4	5	8
Data/Internet	8	0	1
Transportation	0	8	2
Capacity/Meeting Anticipated Increased Demand	9	5	4
Lack of Available Beds	0	8	1

In addition to these barriers, SMHAs identified other areas of TA needs through their MHBG applications. Section 15 of the application specifically asks states for TA requests related to the expansion and delivery of crisis services. In the fiscal year 2022/2023 MHBG applications, 11 states and territories (District of Columbia, Illinois, Kansas, Kentucky, Michigan, Montana, Nevada, New Hampshire, Palau, Puerto Rico, and U.S. Virgin Islands) identified a need for TA in crisis services, the second most commonly identified area of need behind the implementation of evidence-based practices for early SMIs.⁴⁸

Echoing challenges identified in the state profiles, specific areas of TA need states noted in their applications include:⁴⁹

- Transitioning behavioral health crisis calls from 911 to the Lifeline and the crisis service system
- Financing crisis services, especially because the Lifeline increased demand
- Establishing best practices in mobile crisis response, especially in rural and remote areas

Other TA needs SMHAs identified and submitted to NASMHPD's divisional listservs include:⁵⁰

- How the IMD exclusion affects the delivery of crisis stabilization services
- Transportation and mobile crisis (i.e., how to finance and to develop policy to support)
- How to address complex cases that involve risk of self-injurious behaviors
- Use of screening tools for suicidality
- Crisis prevention, de-escalation, and intervention training for law enforcement
- Providing MCTs to youth and adolescents
- Appropriate crisis stabilization and crisis receiving services for youth and adolescents and how to fund in-home crisis stabilization
- Suicide prevention for youth and adolescents
- Using the Medicaid Rehabilitative Services Option to finance crisis services
- Information sharing between 911, 988, and EMS around the needs of Lifeline callers

The Transformation Transfer Initiative (TTI) Pipeline

SAMHSA, through the Transformation Transfer Initiative (TTI) administered by NASMHPD, has been supporting states in implementing comprehensive behavioral health crisis systems for several years. In 2022, a major focus of TTI funding awards was addressing behavioral health workforce needs in crisis call centers, developing mobile crisis teams, developing crisis receiving and stabilization facilities, and planning diversion initiatives. In 2023, SAMHSA's TTI project is supporting over 50 state funding awards that expand the work of states in addressing workforce challenges in their crisis service systems. NRI is working with NASMHPD and the 2022 and 2023 TTI states to document their lessons learned and the impact of their projects. During 2023, NRI and NASMHPD held webinars and produced reports to share lessons learned from the TTI projects with state and local community crisis providers.

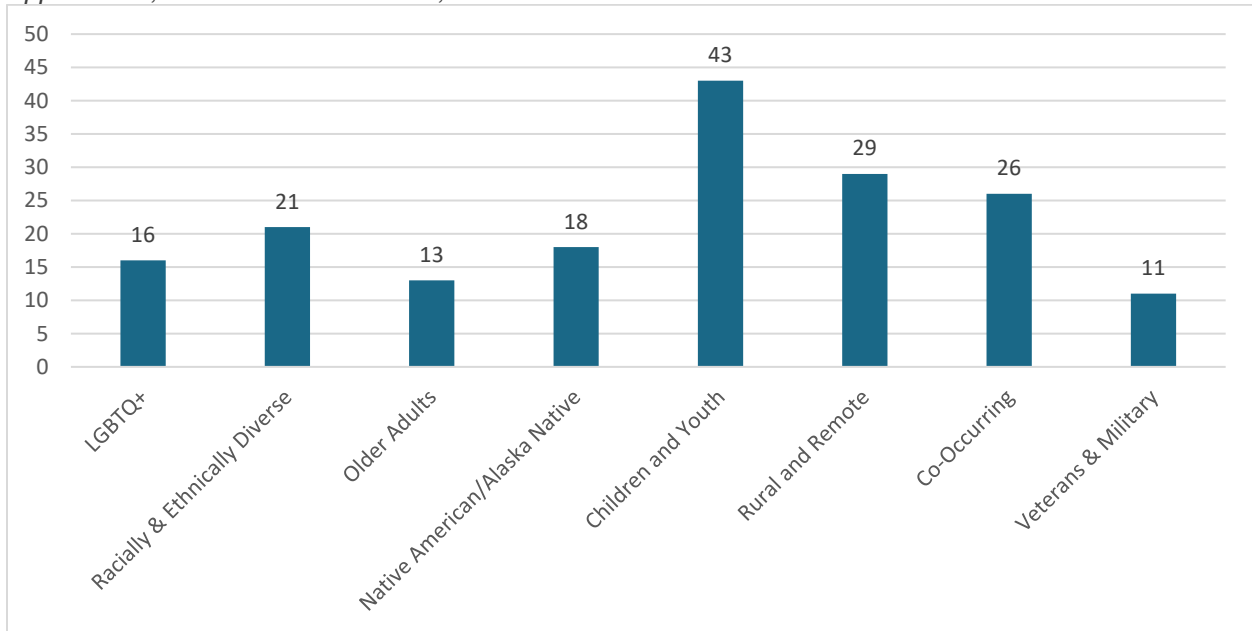
SAMHSA TTI funding has supported states developing training curricula for peer specialists and other behavioral health workers. For example, Utah used their TTI funds to develop a Crisis Worker Curriculum and Certification Program and have shared their work with other states. Mississippi developed a court liaison position that helps individuals with a behavioral health disorder who are involved with the criminal justice system access community-based behavioral health services. The goal of this position is to get people into appropriate care sooner and reduce usage of acute inpatient psychiatric services. New Jersey is planning to enhance the role of peers within the state by establishing a peer mentorship program and an advanced level training curriculum for peers. The Northern Mariana Islands will use TTI funds to increase the number of certified behavioral health professionals and to create a training program for certified behavioral health aides.

As noted earlier, Oklahoma is an early leader of innovative initiatives to improve crisis services. Oklahoma used TTI funds to develop a *Clinical Training Center of Excellence* to manage the training of new and existing behavioral health staff, with a goal to increase the use of evidence-based practices and consistent service delivery throughout the state. Oklahoma has also increased access to behavioral health professionals during crises by developing applications that enables LEOs to use iPads to immediately connect individuals in crisis to qualified crisis workers 24/7. Oklahoma has shared their experience using tablets to enhance access to the behavioral health workforce in other states. Delaware, New Mexico, New York, South Carolina, South Dakota, and others are building on the Oklahoma experience to use technology that enhances access to behavioral health crisis professionals.

Crisis Services for Special Populations

In their MHBG Applications, COVID Relief Funding Plans, and ARPA Plans, states identified efforts to tailor crisis services for individuals among special populations, including the LGBTQI+ community, racial and ethnic minorities, older adults, American Indian/Alaska Natives, children and youth, veterans, and individuals living in rural and remote areas of the country. SMHAs most often identified services for children and youth in each of their applications, followed by services for individuals with co-occurring substance use needs, and for individuals living and receiving services in rural and remote areas. See Figure 6.

Figure 6: Number of SMHAs Identifying Crisis Services for Special Populations in their 2022/2023 MHBG Applications, COVID-19 Relief Plans, and ARPA Plans

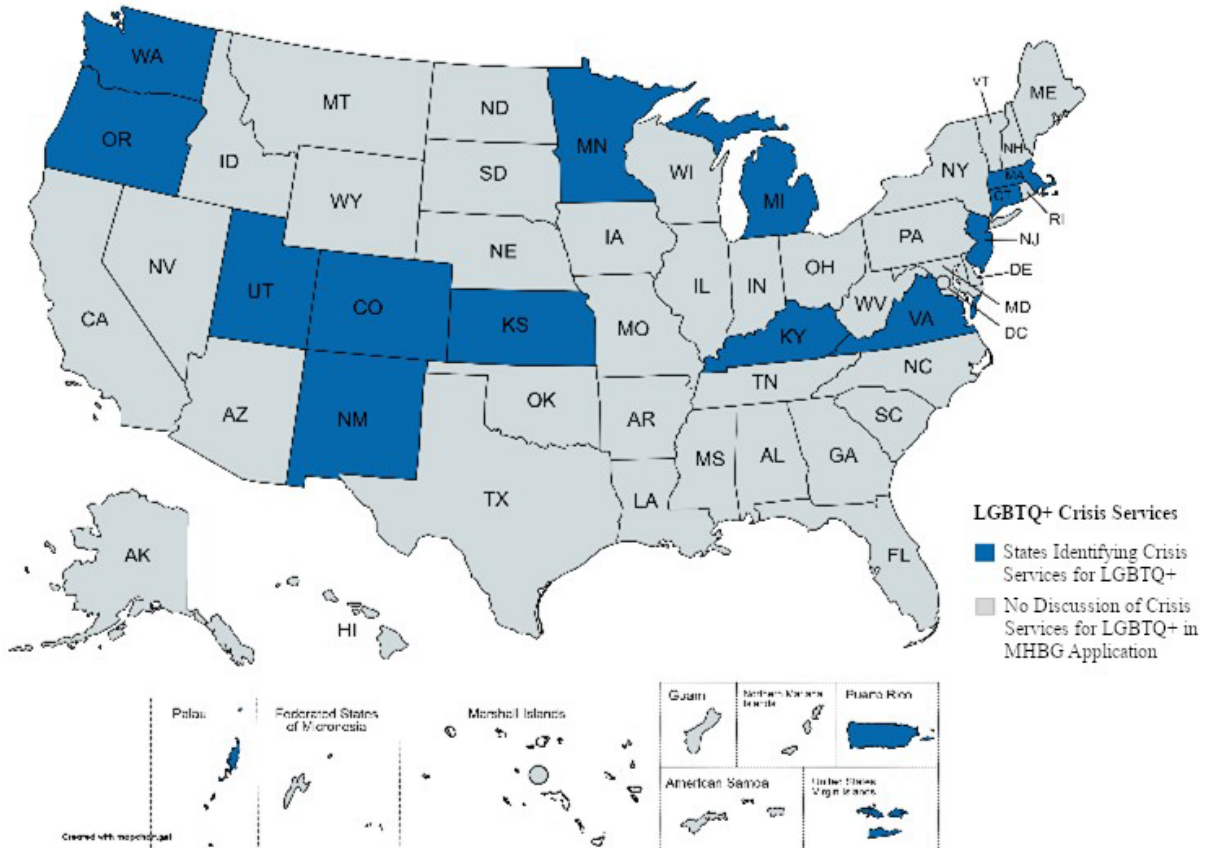


The sub-sections below provide an overview of efforts related to serving special populations in crisis services systems that SMHAs identified in their MHBG, COVID-19 relief fund, and ARPA plans. A complete list of efforts identified by states related to special populations are listed in Appendix B.

Crisis Services for LGBTQI+ Individuals

Sixteen states and territories (CO, CT, KS, KY, MA, MI, MN, NJ, NM, OR, PR, PW, UT, VA, VI, WA) identified crisis services for individuals in the LGBTQI+ community in at least one of their MHBG, COVID-19, and/or ARPA plans submitted to SAMHSA (Figure 7). Most plans focus on training the mental health and crisis workforce to respond to the unique needs of individuals within the LGBTQI+ community. The SMHAs in Kansas and Puerto Rico identified specific activities related to improving Lifeline services for LGBTQI+ individuals. New Jersey plans to increase outreach, treatment, and services to LGBTQI+ individuals engaged with the acute care system and to enhance mobile outreach for this population. Michigan’s SMHA is tracking the demographic characteristics of individuals who present in crisis centers, including individuals who identify as LGBTQI+. Oregon is developing crisis response strategies for working with LGBTQI+ individuals who are at higher risk for suicide, and is using ARPA funds to support trainings for providers that focus on how to better meet the needs of underserved communities.

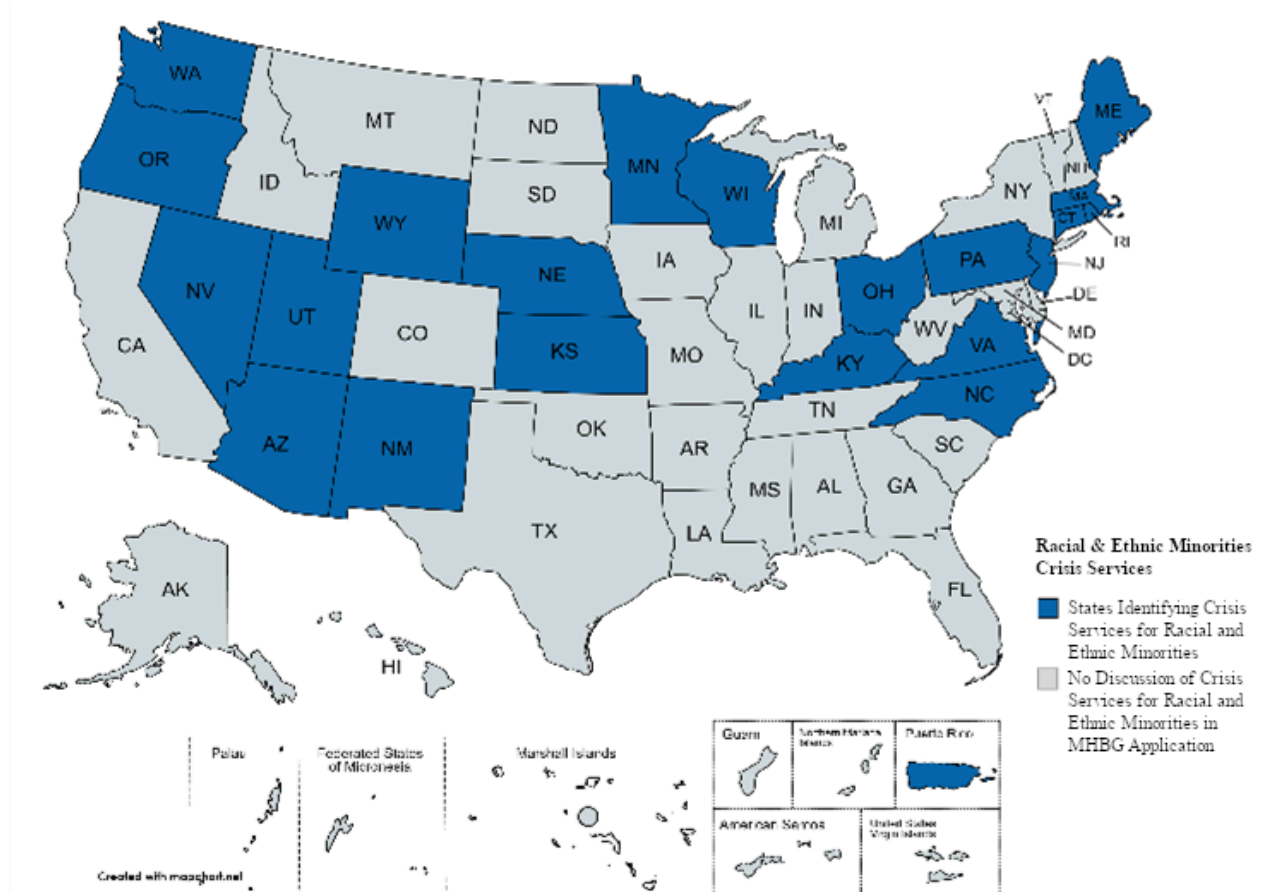
Figure 7: SMHAs Identifying Crisis Services for LGBTQI+ Individuals in MHBG, COVID-19, and/or ARPA Plans



Crisis Services for Racially and Ethnically Diverse Communities

Twenty-one states and territories (AZ, CT, KS, ME, MA, MN, NE, NV, NJ, NM, NC, OH, OR, PA, PR, RI, UT, VA, WA, WI, WY) recognized racially and ethnically diverse communities in their 2022/2023 MHBG applications, COVID-19 relief plans, and/or ARPA plans submitted to SAMHSA (Figure 8). Few narratives describe how crisis services systems will be tailored to address the unique needs of diverse racial and ethnic communities; however, SMHAs acknowledge that individuals from these communities are over-represented in the mental health and correctional systems and are training providers and staff to provide culturally responsive services to these diverse communities to improve services and outcomes. Oregon has developed an advisory workgroup to focus on improving overall crisis services for Black, Indigenous, People of Color (BIPOC) communities, and Virginia is establishing networks of crisis providers to ensure that there is robust representation and relationships between the regional mobile crisis hubs and peer-led and BIPOC-led crisis services networks and providers, research organizations, and social and racial justice-focused behavioral health organizations. Wisconsin acknowledged in its COVID-19 relief plan the need to support historically underserved communities in its crisis services system and will do so through the implementation of a statewide warmline run by peers who will support diverse populations across the state and identify as Latinx, Black, or Hmong.

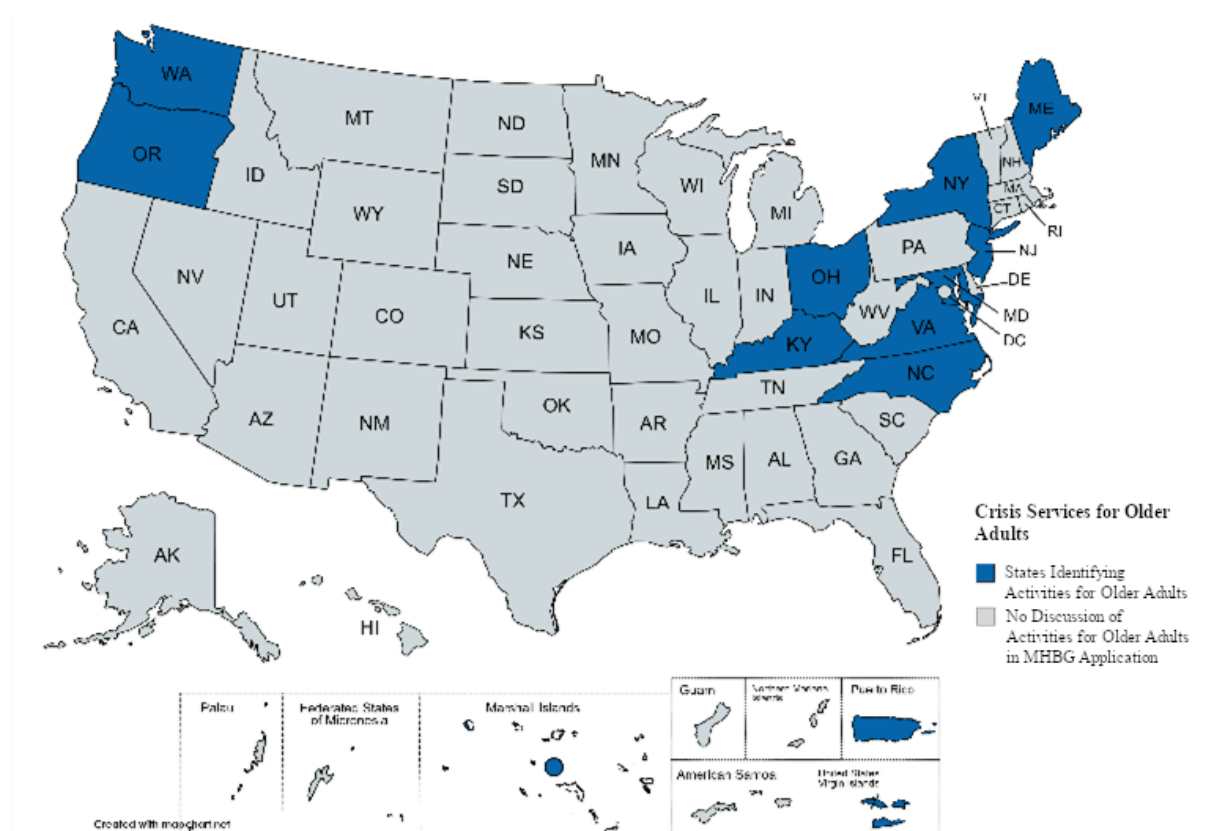
Figure 8: SMHAs Identifying Crisis Services for Racial and Ethnic Minorities in MHBG, COVID-19, and/or ARPA Plans



Crisis Services for Older Adults

Thirteen states and territories (KY, ME, MD, NJ, NY, NC, OH, OR, PR, MH, VA, VI, WA) identified efforts related to improving services for older adults in their 2022/2023 MHBG applications, COVID-19 relief plans, and/or ARPA plans submitted to SAMHSA (Figure 9). Many of the efforts are related to training behavioral health providers, including specialized older-adult peers, to specifically work with the older adult population. SMHAs are also implementing a variety of upstream activities that can reduce older adults’ needs for crisis services. Oregon is developing crisis response strategies for working with older adults. Puerto Rico provides a specialized crisis hotline for older adults, ages 55 and up. The Marshall Islands recognizes that older adults are an important consumer of the services offered through their 24/7 crisis system.

Figure 9: SMHAs Identifying Crisis Services for Older Adults in MHBG, COVID-19, and ARPA Plans



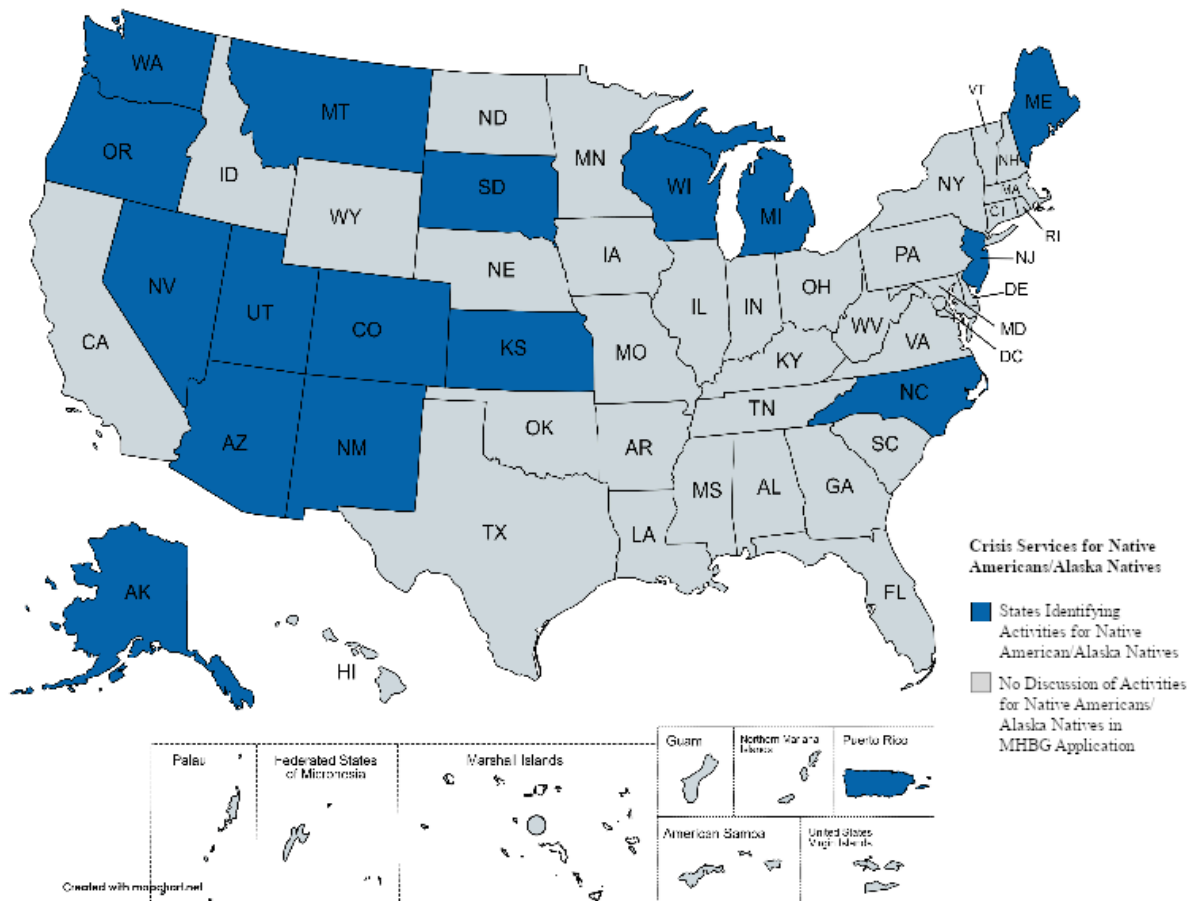
Crisis Services for American Indian and Alaska Natives

Eighteen states and territories (AK, AZ, CO, KS, ME, MI, MT, NV, NJ, NM, NC, OR, PR, SD, UT, WA, WI, WY) identified activities related to improving services for Native Americans and/or Alaska Natives in their 2022/2023 MHBG applications, COVID-19 relief plans, and/or ARPA plans submitted to SAMHSA (Figure 10). Most of these states are collaborating with tribal communities and governments to ensure that services are culturally relevant and meet the unique needs of tribal populations. Alaska’s SMHA recognizes a need to improve access to tribal communities, because many do not have roads that connect to nearby villages, and the only way to travel in and out safely is by air or water. Increasing

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access to and the availability of crisis services in these areas will prevent individuals, including children and youth, from being transported hundreds of miles away from their homes, families, and cultural traditions. Providers in Arizona must have a collaborative agreement in place, whereby tribal liaisons and appropriate clinical staff coordinate crisis services on tribal lands with tribal providers. Colorado is using ARPA funds to provide Ute Mountain Ute first responders with mental health awareness training and crisis mitigation outreach peer services. Maine’s Wabanaki Care Line and other multiple tribal domestic lines supplement crisis services offered directly by the SMHA. Michigan’s Crisis and Access Line is being developed in partnership with tribal communities. Nevada is working with tribal populations to expand Mental Health First Aid, postvention training, and county-specific interventions. New Mexico designed its core crisis components of the crisis continuum of services with input from tribal communities.

Figure 10: SMHAs Identifying Crisis Services for Native Americans and Alaska Natives in MHBG, COVID-19, and ARPA Plans



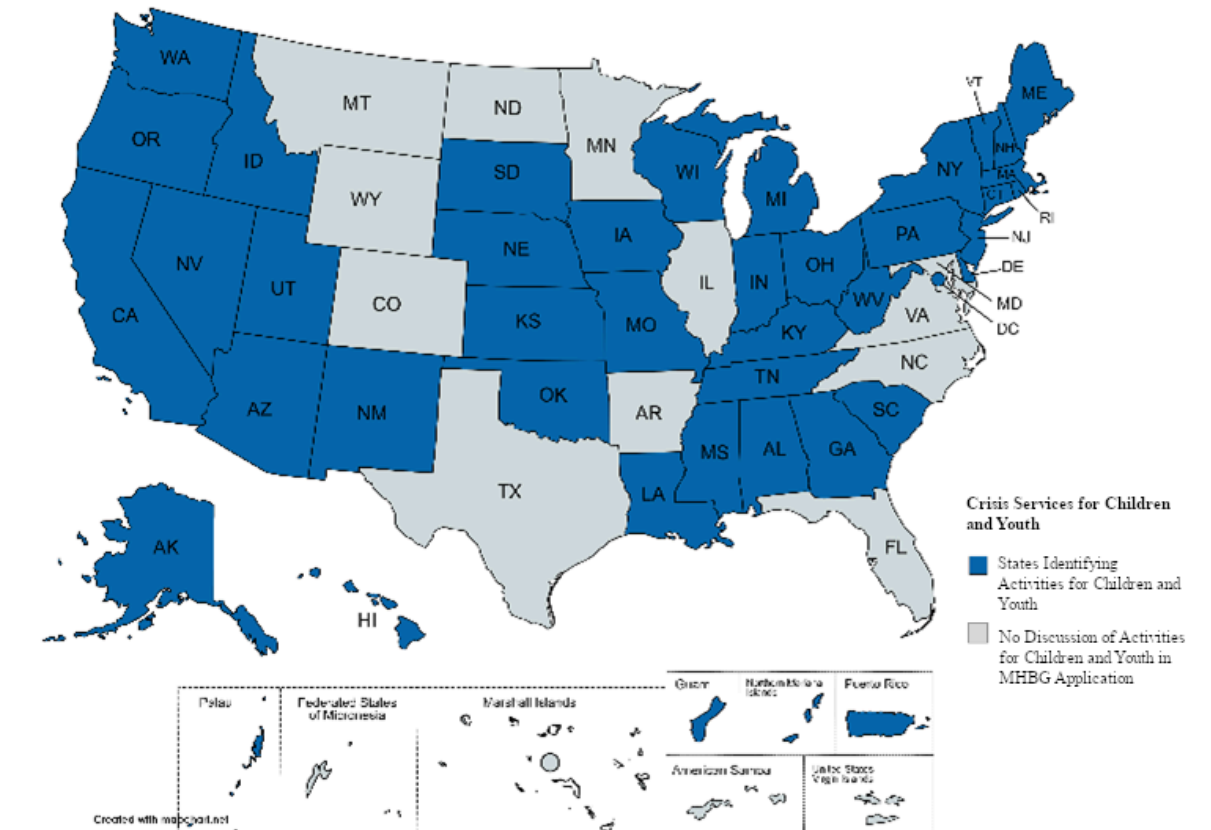
Crisis Services for Children and Youth

Most (43) states and territories identified activities and/or needs related to improving crisis services for children and youth in their 2022/2023 MHBG applications, COVID-19 relief plans, and/or ARPA plans submitted to SAMHSA (Figure 11). Nearly half (20) of these SMHAs identified efforts to expand and improve mobile crisis services for children and youth (AK, CA, CT, DE, DC, GA, HI, ID, MA, MI, MO,

Snapshot of Behavioral Health Crisis Services and Related Technical Assistance Needs Across the U.S.

NJ, NE, NM, OH, OR, RI, TN, UT, WA). Thirteen SMHAs are also investing funds in developing youth-specific and/or in-home crisis stabilization services (ID, IA, LA, ME, MA, MI, NE, NH, NJ, NY, OH, UT, WI). SMHAs also identified efforts to expand crisis services in school-based settings (CA, DC, ID, SD), divert children and youth from emergency departments (GA, ME, MO, VT), expand text and chat capabilities (AZ, NH, NJ, OR), and expand the crisis workforce for children and youth (AK, GU, LA), including an expanded use of children and youth-specific peers (KY, OR).

Figure 11: SMHAs Identifying Crisis Services for Children and Youth in MHBG, COVID-19, and ARPA Plans

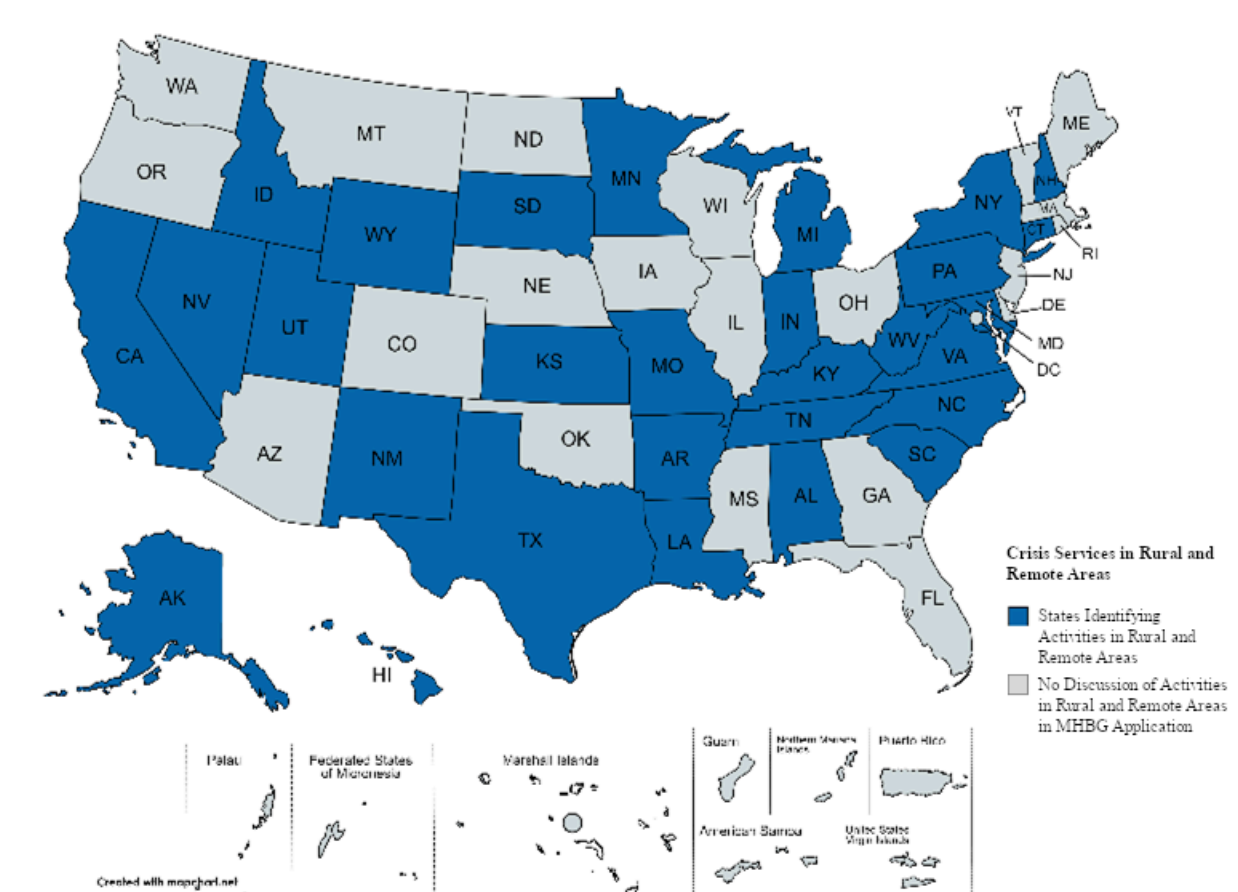


Crisis Services for Individuals Living in Rural and Remote Areas

Twenty-nine states and territories (AL, AK, AR, CA, CT, HI, ID, IN, KS, KY, LA, MD, MI, MN, MO, NV, NH, NM, NY, NC, PA, SC, SD, TN, TX, UT, VA, WV, WY) identified efforts and needs related to improving services for individuals living in rural and remote areas of the U.S. in their 2022/2023 MHBG applications, COVID-19 relief plans, and/or ARPA plans submitted to SAMHSA (Figure 12). Eleven SMHAs (AL, CA, CT, KS, LA, MI, MO, NV, NY, SC, WV) are using funds to expand mobile crisis teams and thereby reduce the amount of time individuals in rural and remote areas are required to wait for services. Other efforts described in the funding plans include expanding crisis stabilization services in rural areas (HI, NV, NC, UT, WY), increasing telehealth capabilities to provide virtual mobile crisis response (ID, MN, NC, TN), encouraging collaborative relationships with primary care providers and other stakeholders to promote collaborative care for individuals in crisis in rural and remote areas (IN, KY, PA), and recruiting and training peers to respond to crisis situations (AL, AR). Many MHBG

applications, COVID-19 relief fund plans, and ARPA plans also noted that workforce shortages and transportation issues are big challenges in rural and remote areas, regardless of service methodology or need (e.g., crisis).

Figure 12: SMHAs Identifying Crisis Services in Rural & Remote Areas in MHBG, COVID-19, and ARPA Plans



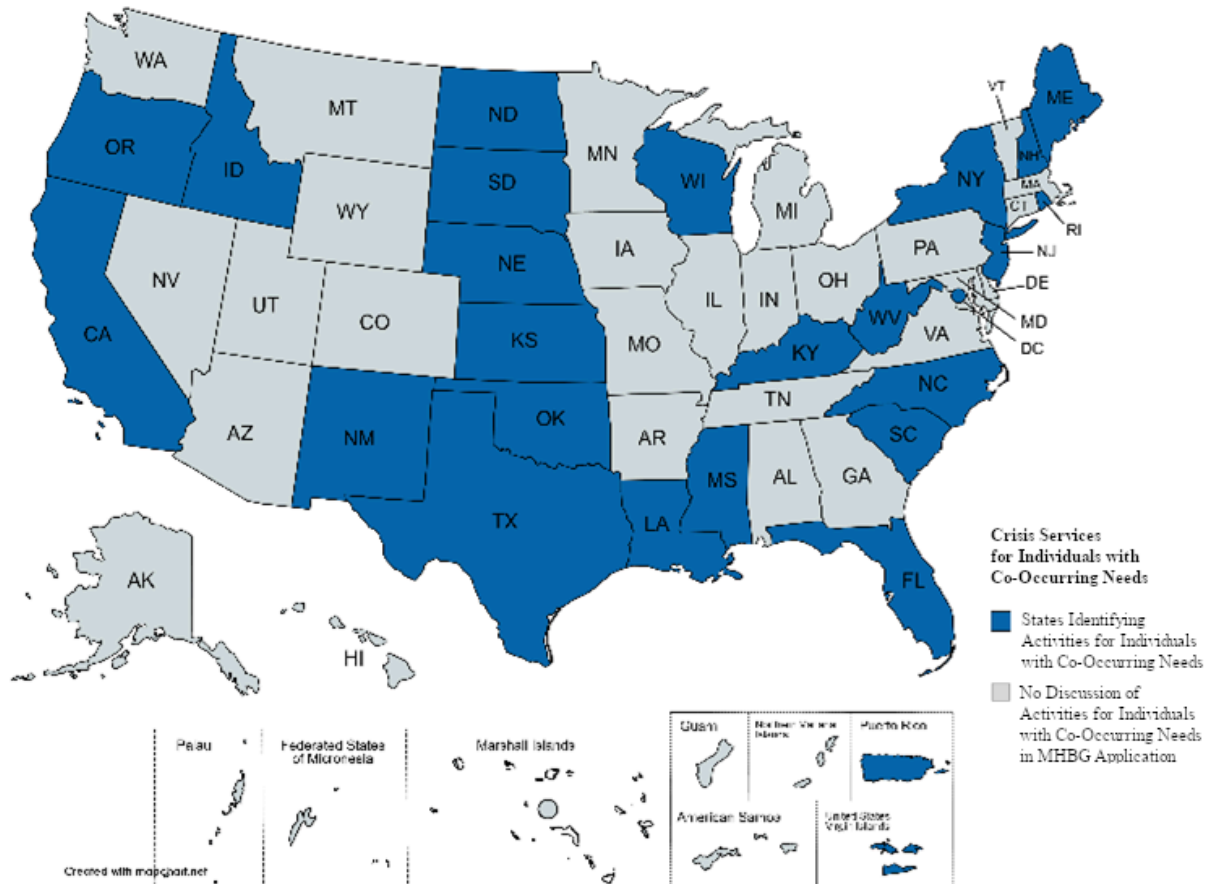
Crisis Services for Individuals with Co-Occurring Needs

Twenty-six states and territories (CA, DC, FL, ID, KS, KY, LA, ME, MS, NE, NH, NJ, NM, NY, NC, ND, OK, OR, PR, RI, SC, SD, TX, VI, WV, WI) identified efforts and needs related to improving crisis services for individuals with co-occurring mental health and substance use needs in their 2022/2023 MHBG applications, COVID-19 relief plans, and/or ARPA plans submitted to SAMHSA (Figure 13). Eight SMHAs (CA, KS, LA, MS, NE, ND, OR, PR) simply recognized that their crisis continuums serve individuals with co-occurring needs. Kansas included problem gambling as a co-occurring need. Nine SMHAs (FL, KY, NH, NJ, NY, OK, SC, SD, WV) identified efforts related to improving services within crisis stabilization units for individuals with co-occurring needs. Six SMHAs (ME, NH, NM, NC, SC, WI) are using funds to ensure their mobile crisis teams are responsive to individuals with co-occurring substance use and mental health needs. Four SMHAs (ID, ME, NY, RI) are ensuring that their crisis services are able to refer individuals with co-occurring needs to appropriate follow-up services. Two SMHAs (KY, RI) are implementing screening instruments to accurately determine an individual’s substance use needs and make treatment recommendations. Other activities are related to mental health,

Snapshot of Behavioral Health Crisis Services and Related Technical Assistance Needs Across the U.S.

substance use, and co-occurring hotlines (TX); training the crisis workforce to better serve individuals with co-occurring needs (VI); and developing co-responder models (ME).

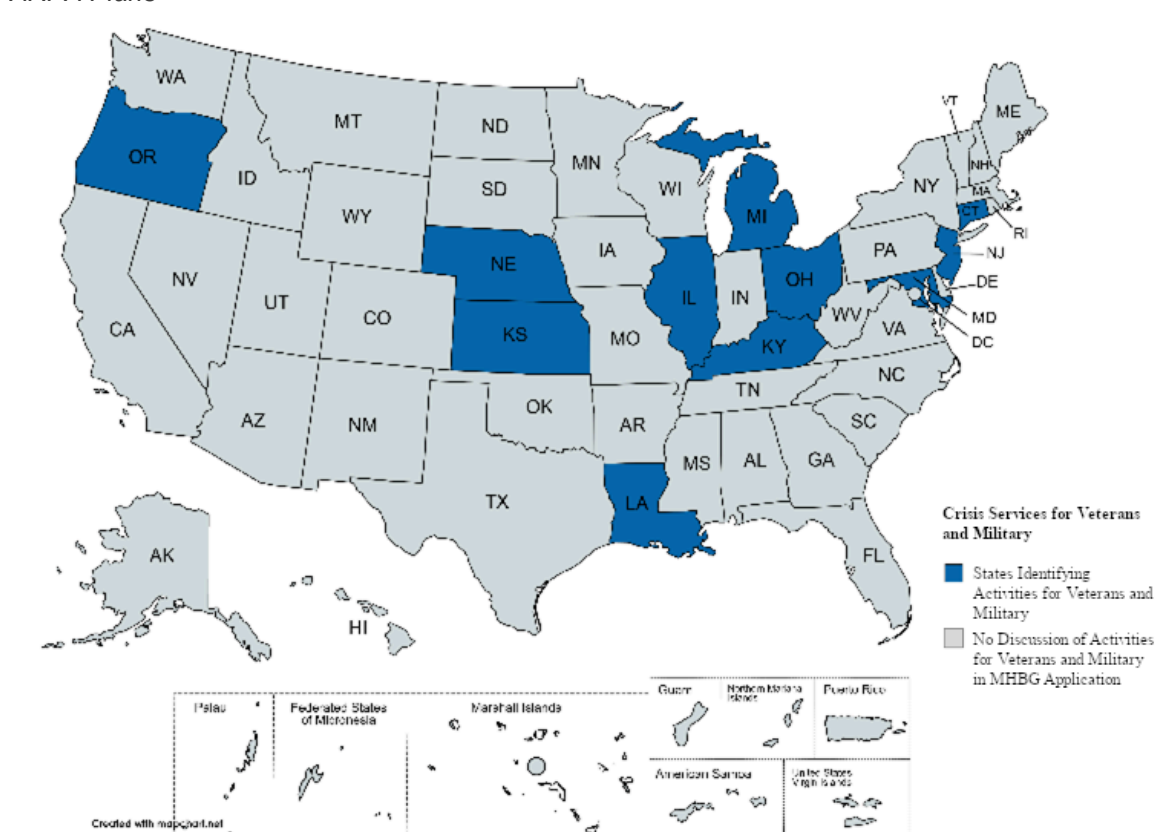
Figure 13: SMHAs Identifying Crisis Services for Individuals with Co-Occurring Needs



Crisis Services for Veterans and the Military

Eleven states (CT, DE, IL, KS, KY, LA, MD, MI, NE, OH, OR) identified activities related to serving veterans and the military in their 2022/2023 MHBG applications, COVID-19 relief plans, and/or ARPA plans submitted to SAMHSA (Figure 14). Connecticut, Delaware, Illinois, Maryland, Ohio, and Oregon have suicide prevention efforts specific to veterans, and Michigan and Nebraska offer a Veterans’ Crisis Line. It is also common for SMHAs to partner with other offices in the state, including their Governor’s Offices and the state Veterans Affairs agencies to make these campaigns and activities successful. Other crisis efforts related to veterans include training staff to be culturally competent to veterans’ needs (KY), training and collaborating with primary care providers (MD), and enhancing Crisis Intervention Team training to be more responsive to veterans’ needs.

Figure 14: SMHAs Identifying Crisis Services for Veterans and the Military in MHBG, COVID-19, and ARPA Plans



Use of Technology to Deliver Behavioral Health Crisis Services

SMHAs identified efforts in their MHBG applications, COVID-19 relief fund plans, and ARPA plans related to the use of technology to enhance the delivery of crisis services. SMHAs are investing in GPS-enabled technology to better collaborate with mobile crisis teams (AZ, AK, CA, GA, KS, MN, MO, NV, NC, TN); enhancing telehealth services to allow for virtual mobile crisis response (AK, AR, CT, DC, FL, ID, IN, MA, MN, NH, PA, SC, WV, WI); providing text and chat options to better engage entire communities in care, particularly youth and young adults who prefer communication via text messaging (AZ, CA, MS, NH, NY, OH, TN, VT); using real-time service registries to support efficient connections to needed resources (AZ, CA, CT, KS, LA, MS, MO, NE, NC, OH, WA); and using scheduling software to facilitate referrals to care, schedule follow-up appointments, and improve overall care collaboration (AZ, DE, MS, MO, NV, NH, NJ, NC, WI). SMHAs are also exploring ways to improve their information technology infrastructure, including expanding the availability of broadband, Wi-Fi, and cellular technology for providers in rural and remote areas (CA, ID, KY, MA, MN, NE, NM, CN, MI, ND, PA, SC, SD, TN, WV, WI). SMHAs are also investing in health information exchanges (AZ, CO, GA, ID, IL, IN, LA, MD, MI, MS, NE, OK, OR), electronic health records software (GU, KS, KY, LA, ME, MA, MI, MS, NH, TN, VA, WA) and other data collection and sharing technologies (VA, WV) to better understand their crisis systems, streamline care, and improve outcomes. Other uses of technology identified by SMHAs that enhance access to and the delivery of crisis services include the following:

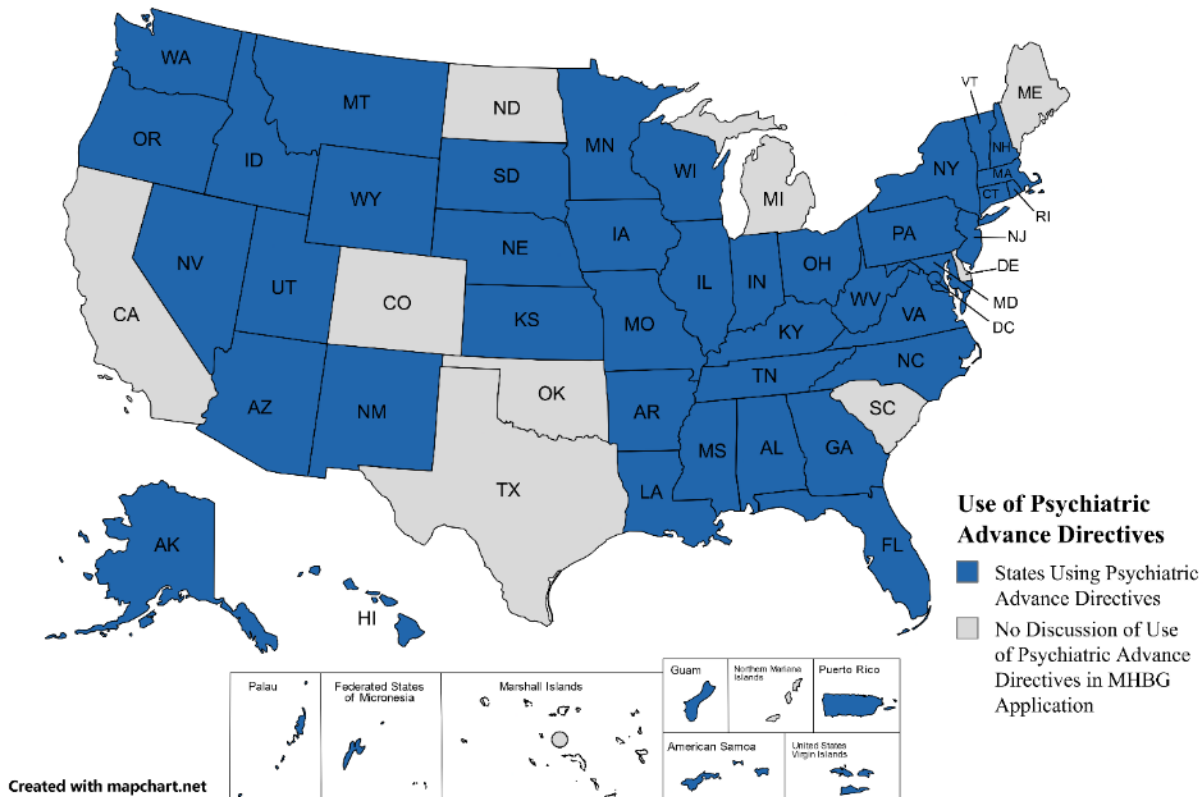
Snapshot of Behavioral Health Crisis Services and Related Technical Assistance Needs Across the U.S.

- Arkansas is equipping Emergency Medical Services vehicles with technology that provides instant access to behavioral health providers when responding to crisis situations.
- Guam uses web-based interpreting services to facilitate communication.
- Puerto Rico is investing in technology responsive to the continuous evolution and adaptation of services to digital platforms.
- Texas is investing in technology infrastructure to complement and enhance the behavioral health workforce, including peer support specialists.
- The Virgin Islands is using technology to raise awareness about SMI and the available resources through different media outlets, including online newspapers, social media accounts, radio stations, and television.

Use of Psychiatric Advance Directives in Crisis Prevention

Psychiatric advance directives describe an individual’s wishes in the event they are unable to express their desires for behavioral health care services and treatments. These are critical tools that enable individuals to be engaged in person-centered care during a psychiatric emergency or behavioral health crisis even if they cannot express themselves. The 2022 MHBG applications asked states to identify whether they use psychiatric advance directives in their crisis prevention and early intervention services. Forty-three SMHAs indicated in their MHBG applications that they do use psychiatric advance directives (Figure 15).

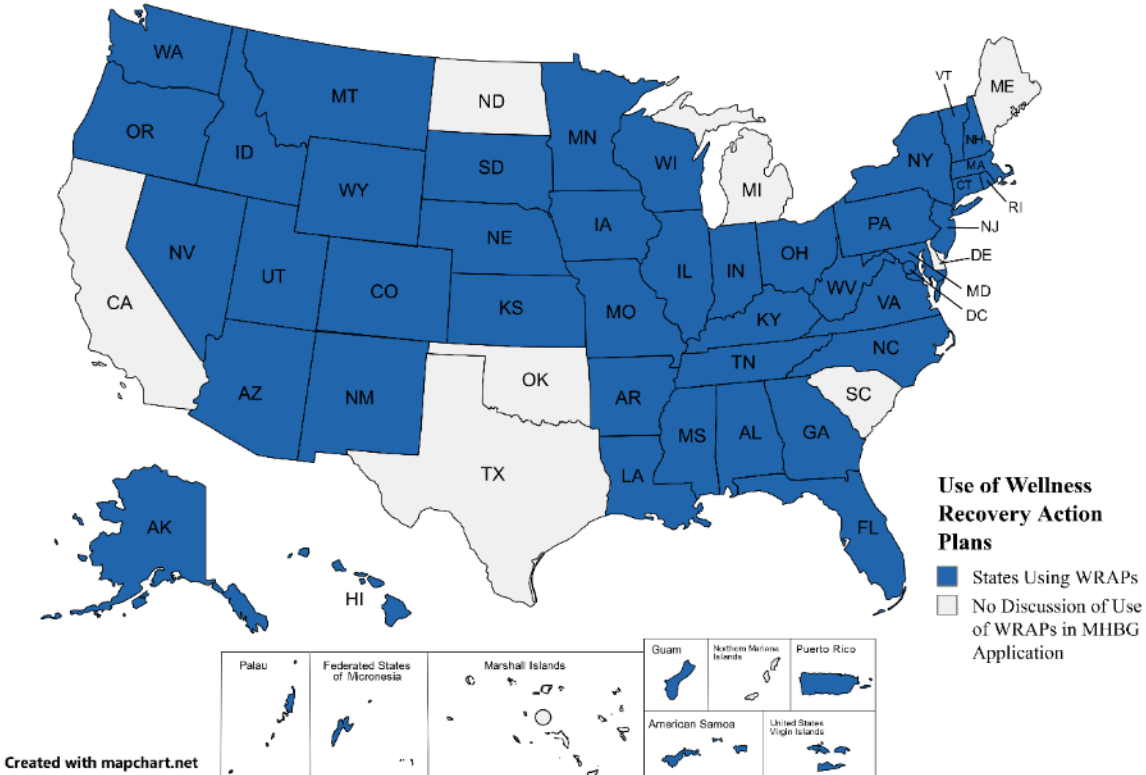
Figure 15: States Using Psychiatric Advance Directives in Crisis Prevention



Wellness Recovery Action Plans (WRAP) and Crisis Planning

Wellness Recovery Action Plans (WRAP) are strategic plans that help individuals with behavioral health needs maintain their emotional health and wellbeing. The 2022 MHBG applications asked states to identify whether they use WRAP as part of their crisis prevention and early intervention services. Forty-eight SMHAs indicated in their MHBG applications that they do use WRAPs as part of their prevention and intervention services. (Figure 16).

Figure 16: States Using WRAP in Crisis Planning

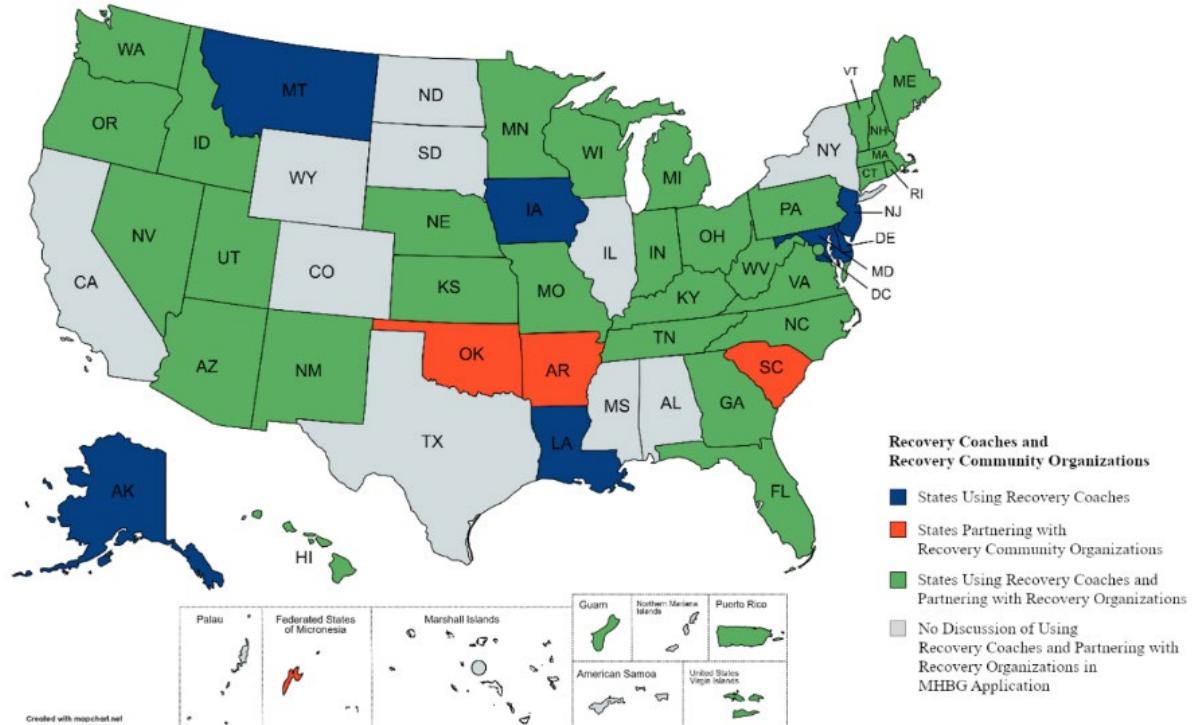


Use of Recovery Coaches and Partnerships with Recovery Community Organizations

Recovery coaches provide mentoring and support to individuals with behavioral health needs who are in the initial stages of recovery. Recovery coaches often have their own lived experience of recovery, and may be certified as a peer support specialist. Recovery coaches may be associated with formal recovery community organizations that bring together individuals in recovery to provide non-clinical services and supports that facilitate the recovery process. The 2022 MHBG application requested states to indicate whether they use recovery coaches and if they have relationships with recovery community organizations to support crisis prevention. Forty-two SMHAs indicated using recovery coaches, and 40 SMHAs identified partnerships with recovery community organizations (Figure 17).

Snapshot of Behavioral Health Crisis Services and Related Technical Assistance Needs Across the U.S.

Figure 17: States Using Recovery Coaches and Partnering with Recovery Community Organizations



Availability of Same-Day and Follow-Up Appointments for Crisis Services

To continue engagement with the behavioral health system and prevent future crises, some SMHAs ensure that same-day and follow-up appointments are available to individuals experiencing a crisis. Nearly all SMHAs (55) indicated in their MHBG, COVID-19, and ARPA plans that they are able to make same-day and/or follow-up appointments for individuals (Figure 18), and 43 SMHAs indicated that their crisis systems are able to make referrals to appropriate services (Figure 19).

Snapshot of Behavioral Health Crisis Services and Related Technical Assistance Needs Across the U.S.

Figure 18: SMHAs with Ability to Make Same-Day and Follow-Up Appointments for Crisis Services

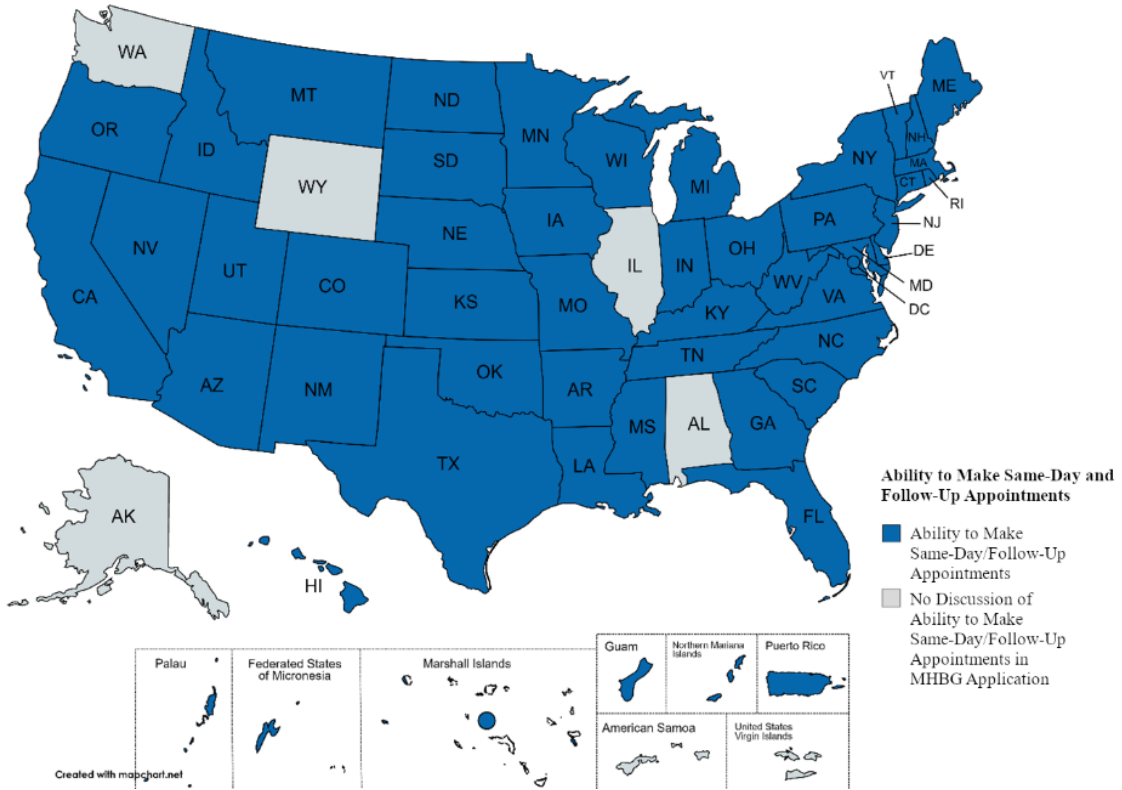
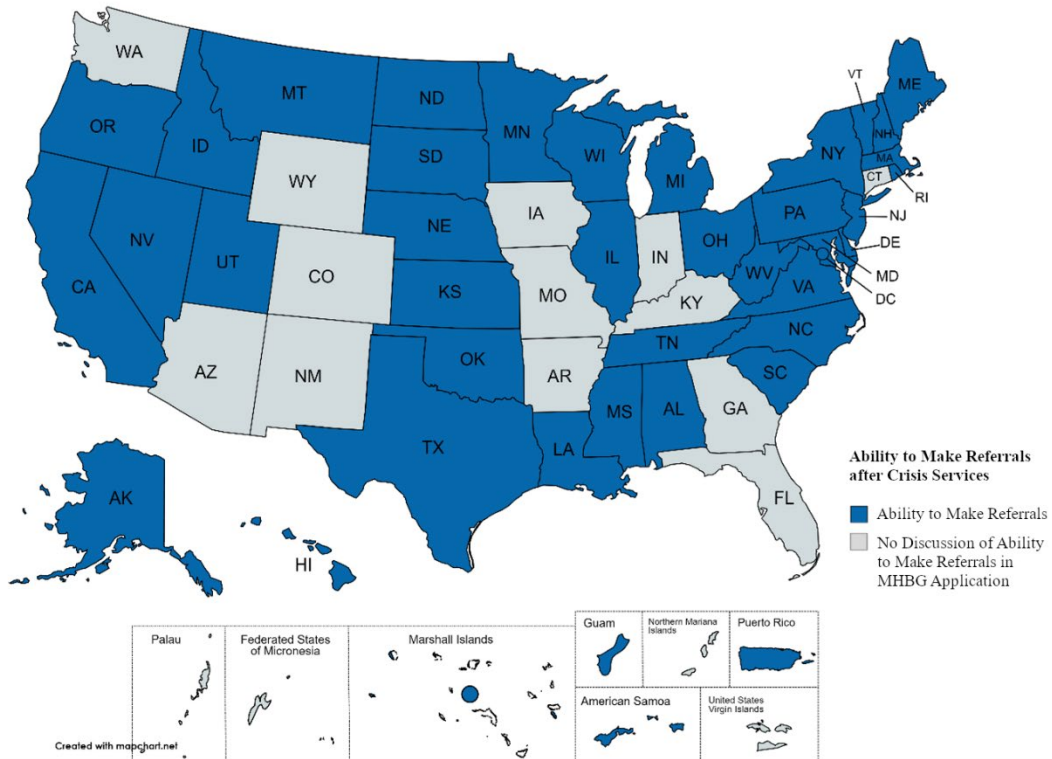


Figure 19: SMHAs Able to Make Referrals for Post-Crisis Services



Limitations on Use of Crisis Services

To sustain the operation of crisis services, SMHAs may limit who can access the services based on ability to pay. Four SMHAs indicated access restrictions to specific crisis services in their MHBG applications and ARPA plans as follows:

- In Connecticut, crisis stabilization beds for children and youth are only available to individuals currently involved with the Child Welfare division.
- In Kansas, short-term respite care is available through the Serious Emotional Disturbance (SED) Waiver and provides temporary direct care and supervision for the participant. The primary goal of this service is to provide relief to the parents and/or caregivers of a participant with an SED.
- Louisiana is actively developing crisis services and supports, including mobile crisis response, behavioral health crisis clinics, and community brief-crisis support for Medicaid-eligible adults. The eventual goal is for the services to be available to all, regardless of ability to pay.
- In Nebraska, individuals who are eligible for Medicaid benefits have access to other crisis interventions, including Crisis Therapy, that non-Medicaid beneficiaries may not be able to access.

Summary

All states recognize the critical importance of the three primary components of a crisis care system, as delineated in SAMHSA's *National Guidelines*: crisis call centers, MCTs, and crisis receiving and stabilization services. Due to the launch of the Lifeline nationwide, states gained access to resources and guidance that enabled them all to operate crisis call centers. There are now more than 200 Lifeline call centers, with 16 more planned.⁵¹ Beyond the Lifeline system, many states continue to operate additional crisis call systems that served over 1.7 million people last year. Eighty-eight percent of states surveyed provide mobile crisis teams and 57 percent provide crisis receiving and stabilization services. Among states not currently operating mobile crisis teams, all indicated that they are working to establish teams.

SMHAs also identified efforts to improve and expand crisis services to special populations, including LGBTQI+ individuals, racially and ethnically diverse communities, older adults, children and youth, Native American/Alaska Natives, and those living in rural and remote communities. To better serve these special populations, most SMHAs are focusing efforts on training and diversifying their crisis workforce to be more representative of those they serve.

States face several major barriers in the implementation of a crisis care system.⁵² One of the largest is the lack of available workforce, which makes it difficult to keep crisis call centers, MCTs, and crisis stabilization services operating 24/7, especially overnight and over the weekend. Workforce shortages are especially acute in rural areas, where states also face other barriers to providing access to crisis services, including the long distances MCTs must travel and a lack of nearby CSUs and short-term CRPs.

States also indicate that funding is an issue for crisis services. Although the 5 percent crisis services set-aside has brought a welcome influx of funds, it does not cover the cost of a statewide, 24/7 crisis care system. States are using additional MHBG funds state general funds, Medicaid (particularly for MCTs) SAMHSA 988 funding, and other sources.⁵³ 42 states reported expending more than \$1.5 billion in 2022 to support their behavioral health crisis service continuums, but this is an inconsistent patchwork of multiple sources (see Table 3). Several have recently implemented a Lifeline fee that will be applied to every phone line within the state (see Table 2: Number of States Using Specific Funding Sources to Support Behavioral Health Crisis Services, 2022). The development of new funding streams, whether a

phone line fee or the ability to bill private insurance and Medicaid enough to cover the crisis services, will be critical for the sustainability of the crisis care system.

The U.S. Territories and Pacific jurisdictions face especially acute challenges to establishing crisis care systems as delineated in the *National Guidelines*. They do not have sufficient local resources to fund a crisis system, and the amount provided by 5 percent set-aside funding is not enough to cover crisis service provision, let alone set up a crisis call center or MCT. Beyond the problem of resources, the distance between islands forms a tremendous barrier among the Pacific jurisdictions to providing timely care via MCTs, CSUs, or other modalities.

States have identified a variety of TA needs in their MHBG applications and through discussions with NASMHPD that include:⁵⁴

- Needing to share information and to coordinate responses between 911 and 988
- Providing mobile crisis services in rural and remote areas
- How to fund in-home crisis stabilization for youth
- How to effectively bill Medicaid for crisis services

Appendix A: Examples of 911 Decision Trees

Figure 20: Didi Hirsch 911 Call Diversion Flow⁵⁵

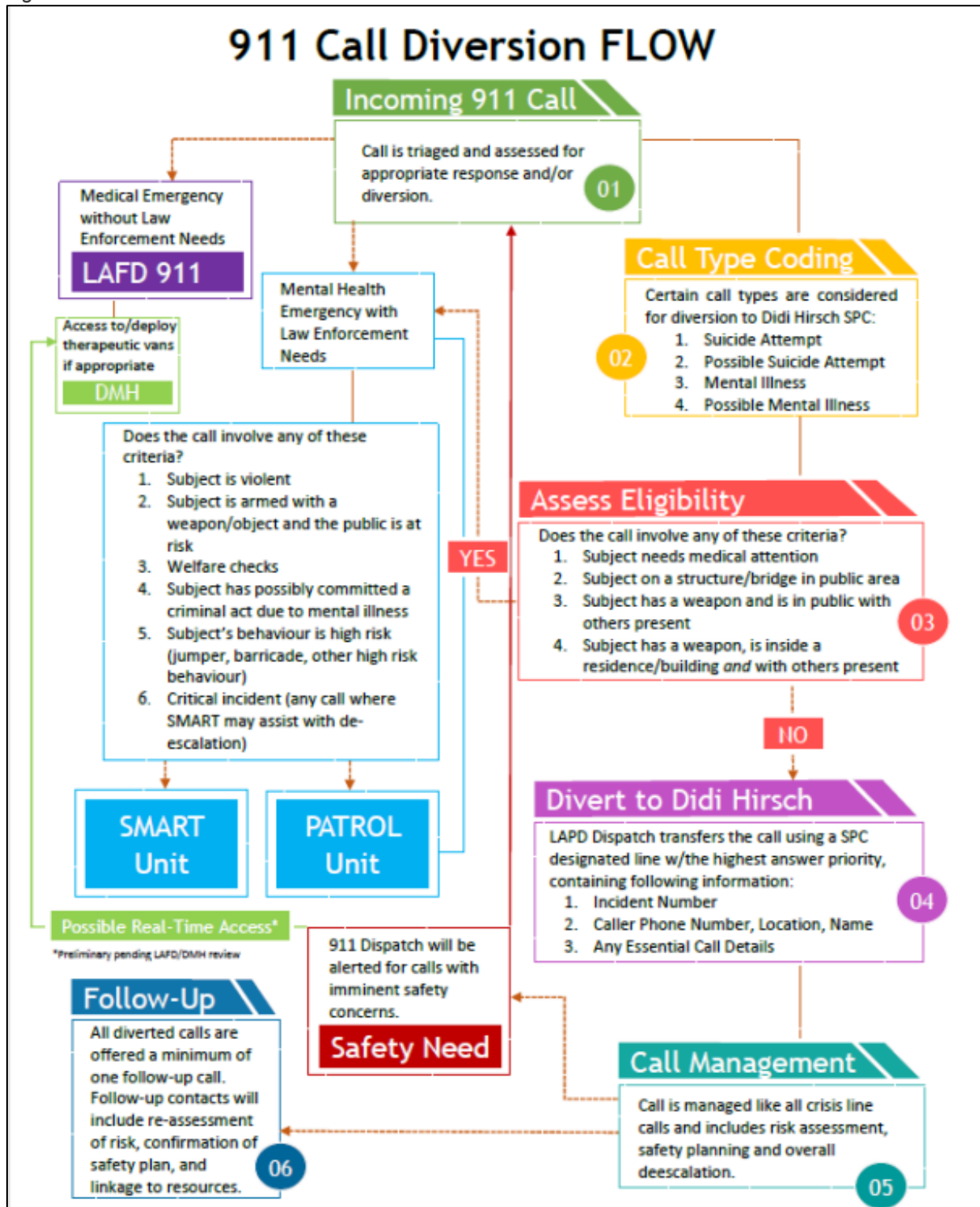


Figure 21: Broome County, NY's 911 Call Diversion Emotionally Distressed Caller Risk Assessment⁵⁶



Appendix B: Efforts by SMHAs for Special Populations Identified in their MHBG, COVID-19 Relief Funds, and ARPA Plan

Each of the activities described in this appendix are taken from SMHA submissions to their 2022/2023 MHBG applications on SAMHSA's WebBGAS system, from their COVID-19 relief plans, and/or from their ARPA plans.

Activities Identified to Improve Crisis Services for LGBTQI+ Individuals:

- Colorado is using COVID-19 relief funds to support one-time projects in identified service gaps for transition-aged youth (ages 16-25) who identify with one or more marginalized identities, including LGBTQI+.
- Connecticut is working with a consultant to identify the unique service needs of LGBTQI+ individuals. The consultant will then develop and deliver a training to the SMHA providers who are working with individuals with SMI in the LGBTQI+ community.
- Hawaii's SMHA recognized in its ARPA plan that LGBTQI+ individuals may be at a higher risk of being victims to human trafficking, acknowledging that specialized services are needed related to this population.
- Kansas is using its SAMHSA TTI Grant to work with community partners to identify the specific individual needs of all LGBTQI+ individuals in the state by providing competent, evidence-based training. Highly trained, culturally competent staff and peer support professionals will be able to ensure services received through 988 are accessible to and inclusive of LGBTQI+ individuals experiencing suicidal ideation or a mental health crisis.
- In Kentucky, crisis staff are being trained to provide culturally responsive services to those identified as high risk, including LGBTQI+. The SMHA is using COVID-19 relief funds to provide targeted outreach to underserved and vulnerable populations, including those most at risk for health disparities due to race, ethnicity, gender, or sexual orientation.
- Massachusetts is using COVID-19 relief funds to support Young Adult Access Centers that provide culturally responsive settings for LGBTQI+ youth and other under-served populations. The Commonwealth is also using ARPA funds to provide culturally competent services to individuals who identify as LGBTQI+, including transgender, non-binary.
- Michigan's SMHA plans to use ARPA funds to augment peer outreach to underserved communities, including those within the LGBTQI+ community. The state is also tracking the demographics of who uses crisis centers, including those who identify as LGBTQI+.
- New Jersey's SMHA plans to increase outreach, treatment, and services to LGBTQI+ individuals to ensure that services are delivered in a culturally competent manner. Additionally, outreach will be extended to address the needs of the acute care service system and enhance mobile outreach services for LGBTQI+ individuals.
- New Mexico is using COVID-19 relief funds to enhance outpatient behavioral health services for LGBTQI+ individuals with an SED/SMI diagnosis.
- Oregon reported in its MHBG application that it is developing crisis response strategies for working with LGBTQI+ individuals who are at a higher risk of suicide. The SMHA is also using ARPA funds to support trainings for providers that focus on how to better meet the needs of underserved communities, including LGBTQI+ individuals.
- Palau's SMHA is allocating some COVID-19 relief funds to an LGBTQI+ organization to better meet the needs of individuals within the LGBTQI+ community with mental health needs.

- Puerto Rico is using MHBG funds to support crisis hotline services for individuals within the LGBTQI+ community.
- The U.S. Virgin Islands acknowledges that individuals within the LGBTQI+ community will be served by ARPA funds.
- Utah’s SMHA is using ARPA funds to partner with community agencies that provide peer support and case management care to marginalized populations, including those in the LGBTQI+ community, and those who are in plural marriage arrangements.
- Virginia is using COVID-19 relief funds and ARPA funds to develop and continue training-the-trainers for specialized LGBTQI+ peer and family support specialists to better serve this community.
- Washington’s SMHA is using COVID-19 relief funds and ARPA funds to ensure training? is offered to diverse clinician groups, including LGBTQI+ providers.

Activities Identified by SMHAs to Improve Crisis Services for Racially and Ethnically Diverse Communities:

- Arizona indicated in its COVID-19 relief and ARPA plans that it will use funds to address the mental health needs of individuals in the juvenile justice system to reduce the risk of recidivism for racial and ethnic minoritized communities.
- Connecticut’s SMHA plans to use COVID-19 relief funds in New Haven and Hartford for agencies working primarily with Hispanic and African American individuals with SMI.
- Kansas’s SMHA is part of the Mobile Response and Stabilization Services (MRSS) Quality Learning Collaborative through the Institute for Innovation and Implementation at the university of Maryland. MRSS plays a critical role in preventing future crises, and reducing involvement with law enforcement, particularly for children and youth who are Black, Indigenous, and persons of color. The SMHA also recognized in its ARPA plans that specific minoritized communities, including African Americans, American Indian/Alaska Natives, and Native Hawaiians/Other Pacific Islanders are over-represented in mental health services in comparison to their Kansas population totals.
- In Kentucky, crisis staff are being trained to provide culturally responsive services to individuals identified as high risk, including Black, Indigenous, People of Color. To address the health disparities and need? to outreach and engage underserved and vulnerable populations, the SMHA has hired an Executive Advisor to the Commissioner and created a variety of workgroups to bring together expertise and resources to address racial and ethnic disparities specific to behavioral health. Targeted outreach to underserved and vulnerable populations, including those most at risk for health disparities due to race and ethnicity.
- Maine’s SMHA directly funded BIPOC-led agencies that employ Community Health Workers to provide stress management and resiliency supports to residents, with a particular focus on immigrant, refugee, and asylee communities and non-native English speakers, as well as Native populations, Latinx communities, and Black Americans. These affirmative efforts have been in tandem with other state efforts to better support non-white communities.
- In its ARPA plans, Massachusetts’s Department of Mental Health indicates that it is committed to serving the needs of persons living with SMI or SED, including BIPOC and/or Latinx individuals.
- Minnesota’s SMHA is using ARPA funds to train BIPOC-licensed clinicians in early childhood mental health. BIPOC Trainees Early Childhood Staff will collaborate with Cultural and Ethnic Minority Infrastructure Grant (CEMIG) Program to train and support licensed clinicians of color

to provide affinity groups to early childhood mental health clinical trainees throughout the state. With this funding, it is estimated that the CEMIG grantees may operate up to five ongoing affinity groups per year for up to 50 childhood clinicians and clinical trainees.

- Nebraska’s SMHA is using COVID-19 relief funds to implement the CLAS/Health Equity Evaluation Tool, Program, and Curriculum to reinforce previous efforts to improve Culturally and Linguistically Appropriate Services (CLAS) and promote health equity in behavioral health programs. The SMHA also indicated that it will use ARPA funding to provide funds to integrate behavioral health clinicians and/or peer support specialists in Federally Qualified Health Centers (FQHCs) or other primary care settings and for training and consultation to address disparities, increase diversity and health equity through cross-system engagement, planning and implementing strategies to strengthen a competent behavioral health workforce which is racially, ethnically, and linguistically diverse to improve engagement of communities of color for SED and SMI services.
- Nevada indicated in its ARPA plan that it is projected to become a minority-majority state by this year (2023), noting that this shift requires approaches that are culturally and linguistically appropriate to improve access to care for all populations. The SMHA also notes in its COVID-19 relief plan that potential barriers to access for diverse populations include structural disadvantages (e.g., socioeconomic) and cultural inequalities (e.g., racial-ethnic group membership).
- New Jersey’s SMHA plans to increase outreach, treatment, and services to racially and ethnically diverse individuals to ensure that services are delivered in a culturally competent manner. Additionally, outreach will be extended to address the needs of the acute care service system and enhance mobile outreach services for these communities. Specific communities identified include Muslim, Haitian, African Americans, and indigenous populations.
- New Mexico indicates in its ARPA plan that service delivery in the state always considers the disproportionately high rates of SMI and SUD in certain communities, especially in Native American and Hispanic populations.
- North Carolina is increasingly focusing efforts on disparities, which requires the evaluation of existing services and policies to identify bias and prejudice. Programs, services, and policies need to be developed that will address racial disparities within the state with respect to mental health and access to appropriate services.
- Ohio is prioritizing access to care with the ultimate goal of improving behavioral healthcare outcomes for racially and ethnically diverse communities who are often underserved.
- Oregon’s Health Authority established the Crisis System Advisory Workgroup (CSAW) which was established to listen, learn, and understand how marginalized populations, especially BIPOC communities, would want to experience a crisis response when they call 988 or receive crisis response services. CSAW has included the following representation: individuals and families with lived experiences, including those from BIPOC communities. In addition, Oregon’s SMHA indicated in its ARPA plans that it is using the funds to develop and distribute toolkits, written handbooks, and interactive trainings for behavioral health providers, created and delivered by people with lived experience. These trainings focus on how to better meet the needs of marginalized and/or underserved communities, including POC.
- Pennsylvania indicates in its COVID-19 relief plans that it will use the funds to allow counties to expand the use of telehealth service delivery for behavioral health services in rural and underserved minority and immigrant communities to address existing inequities in access to healthcare.

- Puerto Rico provides crisis services in multiple languages to meet the needs of diverse communities, including English, Spanish, and American Sign Language. Puerto Rico is also developing community-based programs designed to strengthen clinical services for minoritized populations and residents of low-income communities.
- Rhode Island is attempting to reduce disparities and promote equity through the implementation of student assistance counselors in all middle and high schools, prioritizing those schools that serve diverse racial and ethnic communities.
- Utah is focusing its COVID-19 relief funds on culturally and linguistically responsive services focusing on cultural and racial disparities and the linguistic needs for non-English speaking individuals, including for individuals who are deaf and hard-of-hearing. In 2020, Utah Strong crisis counselors served nearly 90,000 individuals, providing services in five separate languages, including Spanish and Navajo.
- Virginia is using COVID-19 relief funds to establish a network of crisis providers, researchers, and racial and justice-focused behavioral health organizations to establish trainings, memorandums of understanding, analyses, and other needs to ensure there is robust representation and relationships between the regional mobile crisis hubs and Black-led, peer-led, and BIPOC-led crisis services networks. Additionally, the State is using ARPA funds to develop infrastructure to divert behavioral health emergencies away from 911 towards 988 through the development of cooperative agreements between law enforcement, the expansion of mobile crisis teams, the development of community care teams (which may or may not include law enforcement), and the creation of a specialized law enforcement response for when they are called to serve a behavioral health crisis.
- Washington indicated in its ARPA plans that all programs supported by the funds will be designed and delivered in a manner sensitive to the needs of all ethnic minorities. Crisis sites will initiate actions to ensure or improve cultural relevance of services for ethnic minorities and other diverse populations that are typically underserved and marginalized in the system. CLAS standards are required for all programs, and the SMHA will promote diversity, equity, and inclusion and provide specific outreach to BIPOC communities, as well as employ staff that represent the population served by the state, ensuring health equity through policy, practices, and resources. The SMHA also indicated that COVID-19 relief funds will be used to support the Foundational Community Support program, which is based on the Permanent Supportive Housing and Individual Placement and Support models. These principles of these practices encompass equity and racial justice through the promotion of choice, flexible voluntary services, and access. This project will support a statewide community-based mental health engagement and service delivery system that acknowledges individual and institutional bias have marginalized members of the communities.
- Wisconsin acknowledged in its COVID-19 relief plans the need to support historically underserved communities in its crisis services system, and will do so through the implementation of a statewide warmline run by peers that will support diverse populations across the state who identify as Latinx, Black, or Hmong
- Wyoming noted in its MHBG application a priority to improve services for racially and ethnically diverse communities.

Activities Identified to Improve Crisis Services for Older Adults

- In its MHBG application, Colorado noted that fewer older adults sought in-person crisis services during the pandemic. The SMHA also indicated in its COVID-19 relief plan that it has enhanced

outreach and referral processes to ensure access to information about the consequences of substance use is available to all groups, including older adults.

- Maine’s ARPA plan indicates that the SMHA is providing Mental Health Intensive Outpatient Comprehensive Services, which are high-intensity services to avoid hospitalization and offer step-down care that provide focused programs for a variety of populations, including older adults.
- Maryland’s SMHA noted in its COVID-19 relief plan that it would like to provide wrap around services for older adults. The SMHA is also planning an Intervention Recovery and Support program that allows for the continuation of the provision of Family Peer Support and Navigation services to families of adult loved ones, including older adults, with a mental health challenge/concern or disorder.
- Through its ARPA funds, New Jersey is supporting PEARLS (Program to Encourage Active, Rewarding Lives for Seniors). PEARLS is a home-based setting via an outreach program that utilizes a social worker to provide eight sessions of problem-solving treatment over a 19-week period combined with increased participation in activities that the individual finds enjoyable. Staffing of the program includes a consulting psychiatrist, LCSW or LPC, and ideally collaboration with the individual’s primary care physician.
- New York’s Office of Mental Health is looking to expand workforce training opportunities, including the training of law enforcement on diversion techniques, to best support special populations, including older adults with mental illnesses.
- North Carolina indicated in its ARPA plan that it is expanding access to prevention treatment services and older adult specialty peers.
- Ohio’s SMHA is engaged in a Senior Vulnerability and Density Mapping Project to better serve older adults with SMI.
- Oregon is developing crisis response strategies for working with older adults.
- The Republic of the Marshall Islands acknowledged that its crisis system strives to meet the behavioral health crisis needs of older adults in its ARPA plans.
- The Virgin Islands Department of Human Services offers a series of social services to enhance the quality of life for individuals and families with diverse needs, including older adult protection services.
- Virginia is implementing the Certified Older Adult Peer Specialist Program, which is designed to train peer specialists as older adult behavioral health specialists and wellness coaches.
- Washington’s SMHA is using COVID-19 relief funds to develop a curriculum for a 100-hour course for mental health professionals to secure credentials to become focused providers, including Older Adult Mental Health Specialists.

Activities Identified to Improve Crisis Services for Native Americans and Alaska Natives

- Alaska’s SMHA is working with the tribal health system and providers to deliver crisis services. IT is challenging, as many Alaska Native and American Indian communities do not have roads that connect to nearby villages. Typically, the only way to travel in and out safely is by plane or water. Due to the state’s vast geography, Alaska has struggled to embrace crisis services in every community, which has resulted in children and youth in crisis being transported hundreds of miles away from their homes, families, and cultural traditions.
- Arizona’s regional behavioral health authority contractors must provide the full range of crisis services on tribal lands as dictated by each tribe within their region. There must also be a process

in place where tribal liaisons and appropriate clinical staff coordinate crisis services on tribal lands with tribal providers.

- Colorado is using ARPA funds to provide Ute Mountain Ute first responders with mental health awareness training and crisis mitigation outreach peer services. The SMHA is also supporting peer service expansion with crisis mitigation outside the reservation areas, where most of the Native American/Alaska Native population live.
- Kansas's SMHA has been given the opportunity to be part of the Mobile Response and Stabilization Services Quality Learning Collaborative, which plays a critical role in preventing future crises for a variety of specific populations, including indigenous individuals.
- In Maine, the Wabanaki Care Line and multiple tribal domestic lines supplement the crisis services offered by the SMHA.
- Michigan is developing the Michigan Crisis and Access Line in partnership with tribal communities and other stakeholders.
- Montana is providing enhanced training and TA to healthcare providers, including Tribal Health programs to assess for depression, mental health wellness, and substance misuse.
- Nevada is working with Tribal populations to expand Mental Health First Aid, postvention training, and county-specific interventions.
- Community partners in North Carolina, including Tribes, are providing guidance on the development and implementation of services provided through the SMHA.
- In New Mexico, the core crisis components of the crisis continuum of services was designed with input from Tribal communities. COVID-19 relief funds and ARPA funding will be used to expand outpatient behavioral health services for Native Americans.
- North Carolina is developing and piloting culturally adapted models of care for Native Americans to increase awareness around mental health and first episode psychosis.
- Oregon is collaborating with Tribal communities to raise awareness and increase training around first episode psychosis.
- Puerto Rico is allocating some COVID-19 relief and ARPA funds to one Tribal community for the purpose of planning, implementing, and evaluating the needs of the communities to prevent and treat substance use disorder.
- South Dakota is using its COVID-19 relief funds to increase services to Native Americans, the state's leading minority population.
- Utah-Strong counselors served nearly 90,000 individuals in 2020, showing strong demand for these services, with services offered in five separate languages, including Navajo.
- Washington's SMHA is providing training and support to crisis providers through its MHBG, with a focus on providing culturally appropriate services and effective coordination of care and discharge planning for Native American/Alaska Native clients receiving crisis treatment. Additionally, the state is using COVID-19 relief funds to support a statewide community-based mental health engagement and service delivery system that acknowledges that individual and institutional bias have marginalized members of the state's communities. The funding enhances a system that works toward equity and inclusion, and recognizes that Native American/Alaska Native populations have distinctly unique needs and expectations, and that engagement and treatment services are strategically implemented and culturally relevant. The Health Care Authority will contract with 29 federally recognized Tribes and two Urban Indian Health Organizations to deliver needed mental health services to adults and youth with SMI/SED to prevent, prepare for, and respond to behavioral health gaps within their tribal communities.

- Wisconsin allocated COVID-19 relief funds to counties and Tribal communities to purchase PPE for clients and staff to ensure in-person work and services can continue to be conducted safely.

Activities Identified to Improve Crisis Services for Children and Youth

- Alabama is using ARPA funds to expand Mental Health First Aid Train the Trainer for children, youth, and adults.
- Alaska is using MHBG funds to support the development of youth-focused mobile crisis teams. In its ARPA plans, the SMHA also indicated that it is focusing funding to develop the workforce to work with youth ages 16-24 who are experiencing homelessness and at risk for victimization, and to help them access emergency behavioral health services and work with first responders to support referrals to services. These positions will also provide referrals to crisis stabilization services, as well as offer access to medical services, clothing, and shelter referrals.
- Arizona is prioritizing text and chat capabilities for 988 that have shown to be popular among teenagers and young adults.
- California indicated in its MHBG application that all SMHA-funded Crisis Care Mobile Units must prioritize services to individuals 25 and younger, which may include activities such as conducting needs assessments for youth services, placing mobile units near schools and universities, providing outreach and public education campaigns, and taking measurable steps towards addressing the youth and young adult crisis needs within the community. California also indicated that the SMHA is allocating funding to counties, behavioral health agencies, and joint groups of counties or city behavioral health agencies to provide services to individuals, particularly children and youth, experiencing behavioral health crises.
- Connecticut's Department of Children and Families handles crisis services for children, including the ACTION crisis hotline, and mobile crisis teams specifically for youth. Youth mobile crisis teams are required to respond to 90 percent of calls face-to-face, and 80 percent within 45 minutes. The Department of Children and Families was also part of a coalition to develop the state's plans for 988.
- Youth crisis services in Delaware are provided by Delaware Guidance, which is not part of the Lifeline network. The state indicated in its COVID-19 relief plans that Respite Services will expand the network of trained respite providers to assist youth and families with SED with short-term respite services as an alternative to increased use of crisis beds and reduce out-of-house placements. COVID-19 limited bed capacity while need increased, and equipping providers to manage challenging behaviors and would allow for these youth to be better served short-term outside of a facility. Family peer supports will be expanded to provide services to youth/families with SED to avert the need for more intensive behavioral health services later by providing early supports to the stressors and the limited community supports imposed by COVID restrictions. The state is developing an awareness campaign using print and digital media to educate youth and families with SED about services and supports available through the Department. In its ARPA plans, Delaware indicated that the Department of Children, Youth, and Families will use the funding to enhance the expansion of crisis response services.
- The District of Columbia operates a separate mobile crisis team for children and youth, ages 6-21, called the Children and Adolescent Mobile Psychiatric Service (ChAMPS). In addition, the SMHA also has school mental health services, which includes a crisis component to respond to school-based crises related to trauma, death, and other crises.
- Georgia indicated in its ARPA plans that the Morehouse School of Medicine (MSM) Child and Adolescent Psychiatry Fellows will provide culturally informed psychiatric diagnosis and

treatment to youth with SED participating in community-based programs. Fellows will also provide consultation to pediatricians and hospital emergency departments where youth with SED are presenting in psychiatric crisis, and will also explore opportunities to consult with mobile crisis teams.

- Guam is recruiting counselors, therapists, care coordinators, key family contact coordinator, youth coordinators, and mental health peers to provide outreach and crisis services for the SED/SMI population.
- Hawaii has a separate mobile crisis outreach program for youth. The State is also using COVID-19 relief funds to build capacity for emergency departments to disposition youth and adults in crisis by funding telepsychiatry services for youth on neighbor islands to expedite their time in the hospital.
- Idaho offers flexible funds that can be used for crisis stabilization or to assist youth and family by providing one-time or occasional goods or services (e.g., food, lodging) that may mitigate the identified crisis. Through the COVID-19 relief funds, more schools will be able to join the annual cohort of schools in the Idaho Lives Project, which provides resources to implement evidence-based youth suicide prevention programs. Idaho also indicated in its ARPA plans that children and youth with SED and their families can access crisis services and/or supports through crisis call lines, mobile crisis response, and crisis beds for crisis respite. Each of the seven regions has CMH-trained staff available to provide crisis support by phone.
- Indiana is using COVID-19 relief funds to support a hotline for youth in rural communities.
- Iowa is using MHBG funds to develop more facility-based crisis service options for children.
- Kansas's Department for Children and Families has a Family Crisis Hotline that is provided through Beacon Health Options. This hotline provides crisis response services through a 24/7 hotline for any family with a child under 18, and/or for youth who are in or were in foster care and are under the age of 21. This service is available to all, regardless of ability to pay.
- Kentucky's SMHA offers youth peer support programming, which was designed through a collaborative process with the goal of improving the crisis services system. The state also plans to increase the capacity of its crisis response safety net to appropriately respond to behavioral health crises of adults, youth, young adults, and their families across the state.
- Louisiana provides crisis services to children and youth and their families, including crisis stabilization services. With the COVID-19 relief funds, the State will provide training to enhance mental health treatment response for youth with SED through training staff and leadership of provider agencies, including crisis response.
- In Maine, each district is required to provide up-to-23-hour observation for transition-aged youth. A multidisciplinary team comprised of peers, nursing staff, and clinical oversight provide therapeutic interventions, diagnoses, and stabilization. Community Behavioral Health programs also piloted Intensive Crisis After Care, providing MHRT-CSP and clinical support in the family home post-crisis episode. The goal of the pilot was to move youth that were waiting in EDs for placement in inpatient psychiatric units/residential care to their home and provide an intensive level of support to the family in their natural environment. In addition to moving children from EDs, the service kept families from seeking that level of involvement during a crisis; instead, they called the after-care clinician who immediately met with them to help with their crisis. Families were taught the skills to effectively manage their youth's crisis. The pilot is expanding, and the Crisis Center began serving transition-aged youth (14-17) in March 2022. The utilization for this age group is very low, with the Crisis Center reportedly only serving one youth per month since February, but each month there are multiple visits. Families are taught the skills to effectively

manage their youth's crisis, and the pilot expanded from one district to a full statewide rollout, and its continuation is being supported by ARPA funds. Overall, families report being very satisfied with the service and the CASii assessment tool utilized at intake and discharge indicate that youth make gains, with most scoring in a lower level of care than their initial assessment.

- Massachusetts provides Mobile Crisis Intervention for youth, as well as crisis beds for youth through youth community crisis stabilization programs. Crisis flexible support teams also provide up-to 90 days of intensive, in-home therapeutic support to youth and families to help stabilize an acute behavioral health crisis and prevent the need for an out-of-home treatment intervention.
- When Michigan's SMHA reorganized in March 2022, it created a Crisis Services Section which is leading work on developing a crisis system for all Michiganders based on SAMHSA's National Crisis Services Guidelines. This Section is working closely with other staff to implement services for youth, including mobile crisis for youth which is being implemented by the new Children's Bureau and the Diversion Fund grants. Through its Medicaid program, the state also provides intensive crisis stabilization services for adults and children for enrolled beneficiaries.
- Mississippi is using MHBG funds to establish 28 additional crisis stabilization beds for children and youth.
- Missouri's Youth Emergency Room Enhancement program is expanding its scope to transition youth from hospital or vulnerable settings to community care. These individuals have significant behavioral health needs, are ages 6-17, and not engaged in community behavioral health care. Individuals engaged in this program will typically be experiencing escalating behaviors that, without immediate intervention, may require a higher intensity and duration of services. This program seeks to increase timely connections to behavioral health and family support services, address social determinants of health needs, and diminish barriers to youth and family engagement in services. The Department of Mental Health also supports an Access Crisis Intervention Mobile Crisis Pilot in which the community mental health providers partner with the Children's Division, allowing workers access to mobile crisis teams and family support providers for children placed in relative kinship placement.
- Nebraska has expanded its services to include a Youth Mobile Crisis Response Service, which is designed for youth and adolescents. These teams provide immediate crisis counseling to those in need in the community. Youth Mobile Crisis may partner with law enforcement to assist with risk assessment, provide crisis intervention, crisis stabilization, and refer families to health resources in their communities.
- Nevada is expanding its mobile crisis response for children in both the northern and southern areas of the state through MHBG funds. Additionally, the Department of Children and Families will be working to support the crisis continuum and access of care for youth and adolescents in crisis to develop a youth triage unit in an emergency room to support youth and families and to divert from less-appropriate locations of services, including medical emergency rooms. The state is also looking at strategies to expand the psychiatric access line for youth.
- New Hampshire's Rapid Response System provides easy access to behavioral health care for children, youth, adults, and families in crisis through phone, text, chat, community, office, and telehealth service modalities. The SMHA is also expanding in-home crisis stabilization services for children and youth with SED through ARPA funds.
- New Jersey's Mobile Response and Stabilization Services are designed to help families stabilize youth in home and community settings. These services are available 24/7, 365 days-a-year and provide immediate (within one hour) interventions designed to minimize risk, maintain youth in their current living situations, prevent repeated hospitalizations, stabilize behavioral health needs,

and improve functioning in life domains, including school and home routines. Mobile Response and Stabilization Services deliver services to youth who are vulnerable, experiencing stressors, coping challenges, emotional and/or behavioral symptoms, difficulties with substance use, and/or traumatic circumstances that may compromise the youth's ability to function optimally and thrive within their family/living situation, school, and/or community environments. In addition, New Jersey also offers 2NDFLOOR, a confidential call/text helpline and message board platform for youth and young adults. Youth who contact 2NDFLOOR are assisted with their daily life challenges by professional staff and trained volunteers. The State also has a New Jersey Youth Suicide Prevention Advisory Council that is comprised of appointed New Jersey citizens and state government representatives. This Council examines existing needs and services and makes recommendations for youth suicide reporting, prevention, and intervention.

- In New Mexico, the Children, Youth, and Families Department has begun working to establish mobile crisis response services in different parts of the state to respond to children and family crisis needs. The Behavioral Health Services Division has also entered into discussion with agencies in southern New Mexico to determine the feasibility of mobile crisis services that utilize credentialed and certified behavioral health professionals with independent behavioral health and medical staff on call.
- New York's Children's Health and Behavioral Health Medicaid System Transformation multi-agency workgroup created services to address the behavioral health crisis needs for children and youth. The Office of Mental Health provides funding for services to provide support and stabilization in the community through Crisis Intervention Team training and home-based crisis intervention services for children, youth, and families. Residential Crisis Support, Intensive Crisis Residence, and Children's Crisis Residence. Crisis residential programs are part of an expanding continuum of care in communities. They are designed to provide voluntary, short-term (up to 28 days) interventions to individuals experiencing behavioral health crises; there are currently eight children's crisis residences in operation.
- The Commonwealth of the Northern Mariana Islands offers a specialized children and youth mental health clinic, which responds to all non-suicide risk crises involving children and youth and their families.
- Ohio's Medicaid Managed Care Plan is increasing crisis capacity and infrastructure to develop, evaluate, and expand crisis stabilization for a variety of populations, including children and families, in a variety of settings. The State is also expanding Mobile Response and Stabilization Services, a model that includes structured, face-to-face comprehensive treatment intervention and support services for youth ages 0-21. The State is also investing in Open Bed's crisis module to support up to 60 crisis teams statewide, including teams for children and youth.
- Oklahoma's SMHA operates statewide Children's Mobile Crisis Teams for youth and young adults up to age 25 who are experiencing behavioral health or psychiatric emergencies.
- One of the National Suicide Prevention Lifeline sites in Oregon has been and continues to provide text services through the Youthline, which is focused on youth and young adults experiencing suicidal thoughts. Mobile Crisis Response is also available for children and youth, and may include the use of certified family and youth peer specialists.
- Palau offers crisis services for children and those at risk for maltreatment.
- Pennsylvania's SMHA offers mental health crisis intervention services for children, youth, and their families who exhibit an acute problem of disturbed thought, behavior, mood, and/or social relationships that are immediate, crisis-oriented, and designed to ameliorate and resolve precipitating stress. The State also has the Garrett Lee Smith Youth Suicide Prevention grant that

is working to improve continuity of care across youth-serving systems using the Zero Suicide framework.

- Puerto Rico offers crisis hotline services for youth and young adults, ages 13-24.
- Rhode Island is revamping mobile crisis services for children, and has issued a request for proposals to address mobile response for the children's system. There is also a coordinated effort between the SMHA and the Department of Health on the youth suicide initiative.
- In South Carolina, crisis clinicians provide youth with clinical screening to de-escalate crises and provide linkages to ongoing treatment and other resources.
- South Dakota's SMHA offers 24/7 crisis care services that support screenings and assessments of children and youth. The SMHA is also supporting increased access to behavioral health professionals in schools for youth in crisis and in need of ongoing supports.
- Tennessee's crisis continuum includes children and youth mobile crisis response. The SMHA contracts with 13 community behavioral health providers to operate adult and youth mobile crisis services that are non-hospital, community-based services. Children and youth mobile crisis services are provided to children and youth who are 17 years of age or younger. Four youth-focused mobile crisis teams cover the entire state, inclusive of Tennessee's 95 counties.
- Utah has expanded youth and family crisis stabilization and mobile response services into several previously underserved multiple new areas, further increasing access to services for children, youth, and families. Youth-specific crisis programming is now being provided in all but two counties of the state.
- Vermont is investing its COVID-19 relief funds in hospital diversion programs to reduce youth boarding in the ED.
- Washington's SMHA is in the process of expanding mobile crisis teams around the state and ensuring there is at least one adult and one youth team in each region. Crisis hotline services and face-to-face crisis services are available to all ages on a statewide basis.
- West Virginia's First Choice Services is the call center for several complementary lines supporting youth and adult mental health. The state also has a substance use helpline, Help4WV, which links people of all ages with behavioral health services.
- Wisconsin's SMHA funds four youth crisis stabilization facilities where youth can be placed on a voluntary basis to de-escalate a mental health crisis. Some counties have youth beds available, and there will likely soon be authority for the state to license a small number of youth crisis stabilization facilities.

Activities Identified to Improve Crisis in Rural and Remote Areas

- Alabama is using MHBG funds for five rural providers to implement rural crisis plans. The SMHA worked directly with these five providers to provide technical assistance and guidance with this process to ensure program development was connected to the statewide crisis system of care redesign and tailored to the needs of their particular rural communities. Common in all designs was that mobile crisis teams include co-response with law enforcement and certified peer specialists. ARPA and COVID-19 funds are also being used to implement two additional rural mobile crisis response teams.
- Alaska is using MHBG funds to support the Rural-Remote Emergency Program services to provide behavioral health crisis services in rural and remote areas of the state.
- Arkansas is using ARPA funds to support crisis services in rural and underserved areas of the state by providing funding for peer recovery support teams to respond to individuals in crisis.

- California is increasing efforts to establish and provide a standardized statewide system of mobile crisis units. These efforts include ensuring California minimizes the gaps in resources that smaller, rural counties may experience compared to larger counties to ensure individuals throughout the state have access to appropriate levels of services. Rural communities are among the most challenging for California's current crisis system to reach due to limited transportation and a lack of availability of treatment services.
- Connecticut indicated in its MHBG application that mobile crisis teams are supposed to reach people in rural areas in two hours.
- Hawaii is using COVID-19 relief funds to increase crisis stabilization program options in rural areas, with additional focus on specialty populations.
- Idaho is using COVID-19 relief funds to increase use of telehealth solutions for crisis services when possible, especially to address needs in rural and remote areas of the state.
- Indiana is using COVID-19 relief funds to support a hotline for youth in rural communities to have better access to mental health supports through their primary care physicians.
- Kansas is using MHBG funds to develop and implement mobile crisis teams in four of Kansas's most rural catchment areas.
- The Kentucky Rural Suicide Prevention Project is increasing awareness of resources, creating and disseminating farmer cultural humility trainings for behavioral health providers, including numbers able to recognize suicide risk by providing gatekeeper trainings and increased surveillance to identify high-risk geographic areas based on self-harm emergency department data.
- In Louisiana, mobile crisis teams are available to rural areas and are expected to respond within two hours.
- Maryland is directing COVID-19 relief funds to mostly rural jurisdictions that lack a robust crisis response system and faces challenges due to geographic location and limited community behavioral health services.
- Michigan noted in its MHBG application that rural areas are a special focus of developing crisis services. . The SMHA also noted that the adoption of mobile crisis to fidelity differs between rural and urban regions, with the more rural areas typically struggling with implementation because of demand unpredictability and large coverage areas. The SMHA is using funds to develop a mobile crisis model that will follow SAMHSA standards and will work in both rural and urban areas of the state.
- Minnesota is utilizing ARPA funds for the purchase of iPads and telemedicine platforms/technology to allow for telemedicine delivery of service in rural areas when appropriate to provide immediate response when needed. Funds are also being used to improve the information technology infrastructure, including the availability of broadband and cellular technology for providers, especially in rural and remote areas; the use of GPS to expedite response times; and to remotely meet with individuals in crisis.
- Missouri is using COVID-19 relief funds to enhance mobile outreach capability in rural areas.
- Nevada offers local crisis call lines across the state, including in a rural region that contracts with a provider or after-hour crisis calls. There are four planned crisis stabilization units with the potential for rural partners. The state is also working with rural populations to expand Mental Health First Aid training in rural areas. The SMHA also acknowledged a lack of adequate access to mobile crisis teams in rural and remote areas of the state.
- New Hampshire is implementing mobile crisis and crisis stabilization services in rural areas.

- In New Mexico, mobile crisis teams and crisis receiving models are being developed, with a special focus on assisting and coordinating care for people in rural and frontier communities, and would be dispatched from the call centers.
- New York’s SMHA indicated in its MHBG that mobile crisis services are not provided consistently 24/7/365 consistently across the state, but that counties and regions are moving toward that standard with a goal of 100 percent coverage including rural areas.
- North Carolina offers telepsychiatry services to divert emergency department utilization to accessible alternative community-based crisis stabilization and targeted community-based treatment services and support transitions and sustain treatment services engagement in some of the state’s most rural and historically marginalized communities. Funding is being provided to more than 80 rural hospitals to divert and reduce the utilization of emergency departments in crises.
- Pennsylvania’s SMHA noted in its MHBG application that in order for the crisis system to succeed in the state, counties will need to form partnerships to provide the most comprehensive services while still reaching the majority of Pennsylvanians, whether they live in rural or urban areas.
- South Carolina’s MHBG supports the Highway to Hope Program, which consists of 14 recreational vehicles that primarily serve as mobile office sites in rural areas of the state.
- South Dakota is looking to expand mobile crisis teams to rural, less-populated areas of the state with technological approaches through a Virtual Crisis Care Pilot program. The SMHA is expanding regional crisis stabilization centers to address mental health, and expanding crisis services in the central part of the state. Virtual CIT training for LEOs is also being implemented to support rural agencies that cannot take their officers offline for the traditional 40 hours of training.
- Tennessee is using ARPA funds to advance telehealth opportunities to expand crisis services for hard-to-reach locations, especially rural areas.
- Texas is using ARPA funds to work with local mental/behavioral health authorities to implement new crisis diversion programs in rural areas.
- Utah is working on plans and projections for modified crisis stabilization centers in rural regions of the state, and plans to implement the changes in the third and fourth quarters of fiscal year 2023.
- Virginia is leveraging COVID-19 relief funds to create one position for crisis coordination. This position will facilitate the development of further crisis infrastructure and collaboration to ensure equitable implementation across both urban and rural areas.
- West Virginia is establishing additional children’s mobile crisis response teams in more rural areas of the state, with the goal of decreasing response times to one hour. The expanded crisis response teams will continue the integration of mobile services into the crisis continuum in more rural areas of the state.
- Wyoming is leveraging public and federal funds to support 14 community mental health providers across the state. Four of these providers serve in strategic geographic areas as crisis centers providing acute psychiatric care and crisis stabilization. Access to care, especially crisis care, is often impeded by client proximity to services.

Activities Identified to Improve Crisis Services for Individuals with Co-Occurring Disorders

- California’s SMHA serves individuals experiencing substance use crises and co-occurring mental health and substance use crises.
- The District of Columbia makes crisis specialists and peer support specialists available to accompany individuals with mental health and substance use needs to follow-up appointments as needed.
- Florida has combined crisis stabilization units and addictions receiving facilities for adults and children that serve individuals with co-occurring mental health and substance use.
- Idaho is looking at integrated substance use solutions, which include follow-up for treatment of individuals who need solutions within the crisis response system. The SMHA is also looking to expand the development of crisis services to include specialized intervention services for individuals with co-occurring intellectual and developmental disabilities and behavioral health needs.
- Kansas offers crisis services for individuals with both mental health and substance use needs, including a help line for individuals with substance use needs and problem gambling needs.
- Each community mental health center in Kentucky will have the capacity to respond to individuals in crisis with co-occurring disorders. These providers continue to increase crisis assessment and interventions for individuals with substance use and co-occurring disorders, including ASAM certification of crisis stabilization units, increasing capacity of staff in evidence-based practices, reconfiguring crisis stabilization units to serve individuals with substance use disorders or co-occurring disorders, and training on the administration of Narcan.
- Louisiana’s SMHA makes crisis services available to individuals with co-occurring conditions.
- Maine’s crisis continuum provides linkages and referrals to substance use services for individuals engaged in the crisis system. As part of its commitment to serving the population experiencing co-occurring mental health and substance use disorder issues, the SMHA has established the Overdose Prevention Through Intensive Outreach Naloxone and Safety (OPTIONS) initiative. OPTIONS is a coordinated effort of the SMHA and other state agencies to improve the health of Mainers using substances through harm-reduction strategies, helping them on the road to recovery, and dramatically reducing the number of fatal and non-fatal drug overdoses. The OPTIONS co-responder initiative embeds licensed behavioral health clinicians (OPTIONS liaisons) within local emergency medical services and law enforcement agencies in each Maine county. OPTIONS liaisons respond to co-response/real-time response calls during the moment of crisis, and post-overdose follow-up visits in the days following a substance-use related crisis. Law enforcement partners often accompany OPTIONS liaisons during both co-response calls and post-overdose follow-up visits. OPTIONS liaisons act as a resource for alternative crisis intervention as well as contributing to prevention and follow-up efforts through community education and distribution of harm-reduction resources.
- Mississippi makes crisis services available to individuals with substance use disorders.
- Nebraska’s SMHA contracts with the regional behavioral health authority networks to have a minimum capacity to provide emergency services 24-hours-per-day on an unscheduled basis to address acute psychiatric or substance use emergencies.
- New Hampshire provides mobile crisis teams and crisis stabilization units for individuals with co-occurring disorders, as well as the statewide crisis line for individuals experiencing mental health and substance use crises. The SMHA is using COVID-19 relief funds to make enhancements to

the mental health crisis response system. Specialized mobile crisis teams will provide brief, episode-based interventions to individuals of any age who are experiencing both psychiatric and/or substance use-related crises.

- New Jersey is using supplemental funding to develop additional crisis receiving and stabilization centers in each region of the state in an effort to divert emergency room admissions, inpatient admissions, and to provide services to individuals with SMI, SUD, or co-occurring disorders.
- Mobile crisis teams in New Mexico respond to mental health and substance use emergencies.
- With the COVID-19 relief funds, New York is undertaking programmatic development and implementation of a new integrated mental health/substance use disorder crisis stabilization model, providing support for current crisis stabilization programs, and making connections to follow-up services for children and youth.
- North Carolina has mobile crisis response in all 100 of its counties. COVID-19 relief funds will be used to support the enhancement of seven mobile crisis teams to address specific behavioral health and substance use needs of children and families in crisis.
- North Dakota's eight Human Service Centers have all developed and implemented a crisis management program that provides help 24-hours-per-day, seven-days-per week to residents experiencing mental health, substance use, and emotional crises.
- Oklahoma is using COVID-19 relief funds to expand urgent recovery centers and crisis centers that provide stabilization services and a no-wrong-door approach to mental health and substance use crisis care.
- Oregon offers crisis care to individuals with other co-occurring disorders, including medical disorders and SUD.
- Puerto Rico offers services to address emotional crises due to substance use.
- Rhode Island's current crisis system is designed to provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals. The goals of this project are to provide emergency crisis and evaluation services to reduce emergency department visits and admissions, intervene with crisis services to engage the client in a referral for treatment that will reduce the use of substances, expand access to emergency crisis services after normal business hours, and to provide referrals to treatment services for individuals who have or at risk for substance misuse and untreated behavioral health diagnoses.
- Each mobile recreational vehicle team in South Carolina provides the opportunity for other caregivers, such as substance misuse counselors and/or primary medical care to accompany mental health staff. The state is also supporting crisis services by making mobile crisis response and crisis stabilization units better able to assess and assist in the appropriate disposition of individuals in crisis with co-occurring disorders.
- A community mental health center in South Dakota is operating Safe Bed for individuals with both mental health and substance use disorder short-term crisis needs.
- The Crisis Hotline in Texas is a 24/7 telephone service operated by trained crisis staff providing crisis screening and assessment, crisis intervention services, mental health and substance use referrals, and makes general mental health and substance use information available to the community.
- The Virgin Islands indicated in its MHBG that it recognizes a significant need to increase its capacity to provide treatment services to individuals with SMI, SUD, and co-occurring disorders, especially during the COVID-19 pandemic. Responders will receive a minimum of 40 hours of specialized training in psychiatric diagnoses, suicide intervention, substance use issues, behavioral health de-escalation, the role of family in behavioral health challenges or mental

disorders, behavioral health and substance use laws, and local resources and procedures for individuals in crisis.

- In West Virginia, currently the main way to access intensive adult crisis services in the state is via regional crisis stabilization units which serve both the SUD and mental health populations.
- In Wisconsin, mobile crisis teams will increase reimbursement options, provide improved safety for crisis workers, allow telehealth options, and require harm reduction and substance use treatment training for crisis staff.

Activities to Improve Crisis Services for Veterans and the Military

- Connecticut offers Veteran Suicide Prevention services.
- Through the Delaware Suicide Prevention Coalition, the SMHA collaborates with the Division of Public Health, the Department of Services for Children, Youth, and their Families, the Delaware State Police, and the state's Veterans Affairs and military divisions to identify shared needs and opportunities to address the mental health needs experienced by adults and children in Delaware.
- In Illinois, SMHA staff are in the process of creating a suicide prevention campaign that includes a special focus on veterans, consistent with the Governor's Challenge work, as well as a broader campaign to ensure those at risk are aware of resources.
- In Kansas, the SMHA and the Governor's Behavioral Health Services Planning Council have provided grant funding to veteran's programs and Crisis Intervention Training programs.
- In Kentucky, crisis response staff are being trained to provide culturally responsive services to those identified as high risk, including military-connected families.
- Louisiana's SMHA has entered into a contract with the Louisiana Center for Prevention Resources to provide a training series for service members, veterans, and their families to raise awareness of SMI and SED among the population in an effort to link them to available services and resources.
- Maryland's SMHA identified a current need for safety training that teaches service members, veterans, and their families proper techniques and tools to reduce the potential for a weapon-related accident. The training also provides a focus on suicide prevention for this population who have easy access to weapons. As this training effort targets service members, veterans, and their families who have a national suicide rate 1.5 times that of a non-veteran adult, it is expected that individuals being served through this effort will have an SMI/SED or be the family member of an individual with an SMI/SED. In the state's ARPA plan, the SMHA elaborated that the Intervention, Treatment, and Recovery Support Services project's goal is to expand a primary care provider safety planning training program. The project will host a learning pathway for health care providers, provide safety-planning kits and designation for providers completing the learning pathway, and work in conjunction with jurisdictions conducting crisis intercept mapping (including urban, suburban, and rural). This project is important because not all veterans who experience suicidal ideation or behavior have mental health diagnoses or engage in mental health services. Focusing on primary care staff broadens the scope of suicide prevention, allowing reach to a greater proportion of service members, veterans, and their families not served by the Veterans Affairs Administration.
- Michigan's SMHA involved veterans in the development of their crisis line. The SMHA also has a Veteran Liaison and routinely collaborates with the Michigan Veteran Affairs Agency.
- Nebraska has a Veterans' Crisis Line.
- Ohio sponsors Veteran Gatekeeper Suicide Prevention.

- Oregon's SMHA proposed in its ARPA plans that a veteran/military behavioral health conference would be beneficial to highlight work from the Oregon Health Authority's suicide prevention team.

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