CRISIS CARE AND SERVICE SYSTEMS PART 2: CRISIS SERVICES IMPLEMENTATION AND INFRASTRUCTURE

Series Overview: This course is part of a 3-course series on Crisis Care and Service Systems

Substance abuse and mental illness crisis situations occur in all communities. This series presents SAMHSA's national guidelines and best practices for crisis care, which can be used to strengthen crisis care and reduce the impact of substance abuse, acute mental illness, and suicide in America. The courses in this Crisis Care and Service Systems series are:

SAMHSA's National Guidelines for Behavioral Health Crisis Care: Best Practice Toolkit
Crisis Services Implementation and Infrastructure
Crisis Care for Various Populations

LEARNING OBJECTIVES

Upon completion of this course, the learner will be able to:

1. Describe core elements and services included in the crisis continuum.
2. Explain the positive effect that specialized teams, interventions, and approaches have on crisis situations.
3. Identify ways in which technology is used to improve delivery of crisis services.
4. Explain the role of legal and regulatory issues in behavioral health emergencies.
5. Recognize challenges to receiving and delivering behavioral health crisis services in rural and frontier areas.
6. Differentiate the responses of law enforcement and behavioral health crisis teams in crisis care.

INTRODUCTION

With alarming rate increases in suicides, overdose deaths, and individuals with disabilities in the criminal system, a comprehensive and integrated crisis network is crucial. An effective crisis network is one that implements a multi-disciplinary response as well as uses brief, intermediate, and long-term approaches to crisis care. *Crisis Service Papers Building on SAMHSA's National Guidelines* explores opportunities and challenges to consider when implementing and delivering crisis services as well as strategies to enhance crises response. The purpose of this course is to support social workers, psychologists, marriage and family therapists, and counselors, working within crisis care systems in implementing and/or working collaboratively in a multi-disciplinary crisis response team.

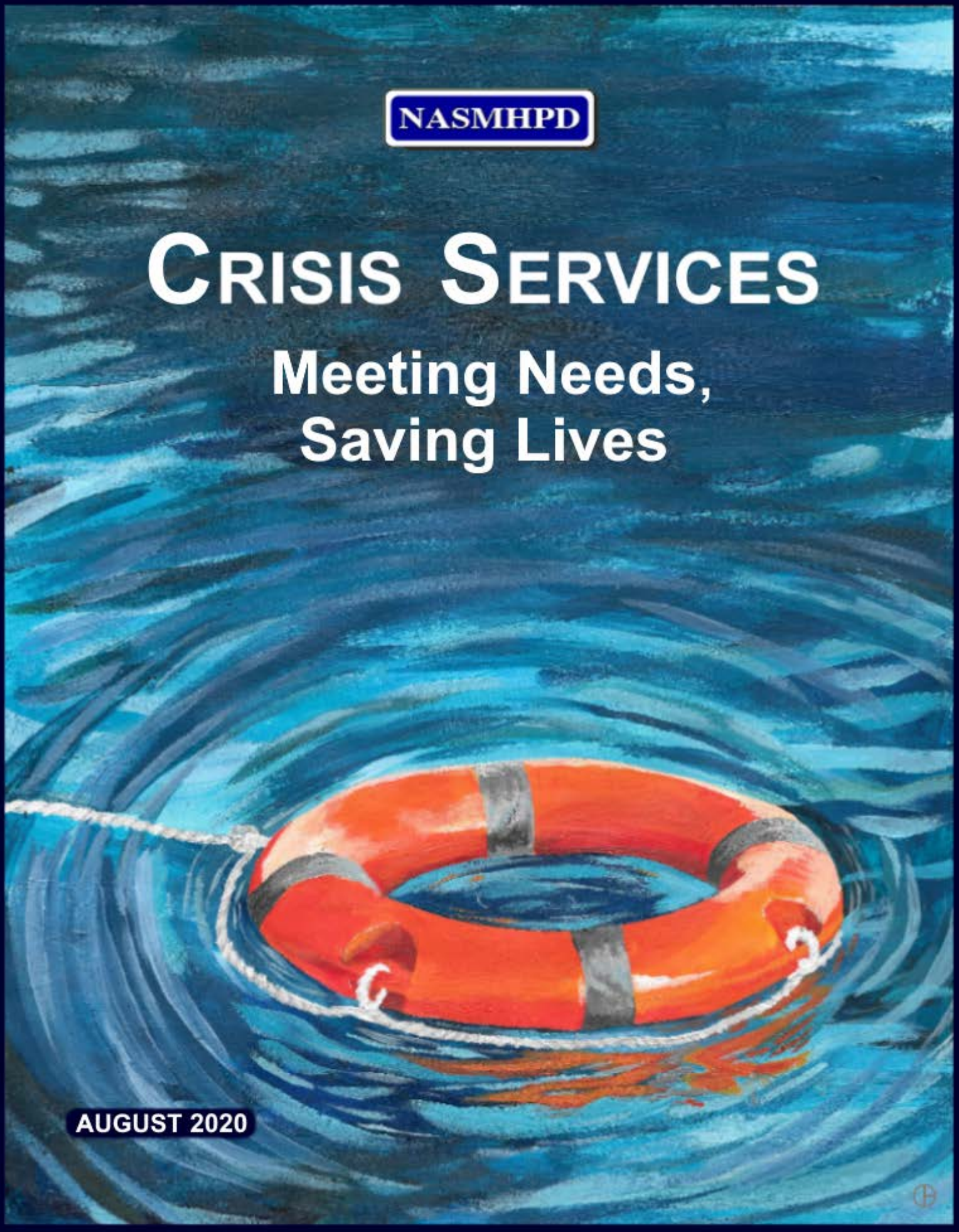
Clinicians can use the discussions on opportunities and challenges to help inform their role in crises care. This practice-focused learning material also offers providers information on technologies and strategies that crisis teams can use to facilitate and enhance the delivery of behavioral health crisis services. Other topics covered include and are not limited to legal and regulatory issues and the role of law enforcement in crisis care. Upon completion of this course, providers will be able to respond more effectively to individuals experiencing behavior health crisis.

This learning material refers to a 988 dialing code that was under consideration by the U.S. Congress at the time the SAMHSA national guidelines were published in 2020. In the summer of 2022, 988 was adopted nationwide. It operates 24 hours a day, 7 days a week, connecting those who call or text immediately to the Suicide and Crisis Lifeline. It is a national network of more than 200 crisis centers that is funded through local, state, and federal sources. Unlike 911, the Suicide and Crisis Lifeline does not have geolocation available, but instead routes calls to the closest crisis center based on the phone number's area code. As 988 continues to be evaluated, modifications to the program are likely to be implemented to improve efficacy. Visit https://www.samhsa.gov/find-help/988 to learn more.

NASMHPD

Crisis Services

Meeting Needs, Saving Lives



AUGUST 2020

Accessible • Interconnected • Effective • Just

Crisis Services: Meeting Needs, Saving Lives

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Disclaimer

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ABSTRACT:

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

This working paper was supported by the Center for Mental Health Services/Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services.

Background

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

Even before the global pandemic, for persons with serious mental illness, prolonged waits in emergency departments[2] have been alarmingly long, and risks of arrest and incarceration, alarmingly high.[3] Forensic services such as waits for competence to stand trial services have been increasingly in demand[4], and they too are subject to the same disparities in care noted in other criminal justice landscapes.[5] Through several initiatives spanning across decades, mental health advocates, government agencies, legislators, and providers have worked to push forward reform. The goal is to have a community system that is interconnected, effective, just and accessible, through well-coordinated services. With this as a reality, many lives could be saved, suicides averted, and even persons with serious mental illness could access quality care and avoid negative outcomes seen too often. In 2017, the National Association of State Mental Health Programs (NASMHPD) together with the Substance Abuse and Mental Health Services Administration (SAMHSA) laid a foundational clarion call with the paper, *Beyond beds: The vital role of the full continuum of psychiatric care*[6] in which the cry for "more beds" was questioned as the single system solution. Instead, that paper pointed to building an infrastructure of a continuum of mental health services and policies to ensure timely access to appropriate care to address serious emotional disturbances and serious mental illness. In subsequent years, NASMHPD put forth bold goals to achieve improved outcomes for mental illness,[7] and in 2019, called for an exploration of nine areas as examples of lessons that could be drawn from the international community to enhance practices and services in the United States to achieve better outcomes for mental health overall.[8]

SAMHSA Crisis Toolkit: A Roadmap for Crisis System Design

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

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

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

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

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

SAMHSA Crisis Toolkit: Benefits of Good Crisis Care

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

The Crisis Continuum

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

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

SAMHSA Crisis Toolkit: Core Elements of a Crisis System

1. Regional or statewide crisis call centers coordinating in real time;

2. Centrally deployed, 24/7 mobile crisis;

3. 23-hour crisis receiving and stabilization programs; and

4. Essential crisis care principles and practices.

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

Beyond Beds

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

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

Table 1: Types of Crisis Services across Systems

Crisis Continuum Component	Model Definitions	Additional Model Functional Components
Warm Lines/Peer Warm Lines	A call line that provides opportunities for talking, receiving support and referrals.	- Link individuals to crisis lines for calls that escalate - May be staffed and managed by peer-run organizations
24-hour Crisis Lines (telephone, text, or chat)	A communication system that provides screening, assessment, preliminary counseling, and resources for referrals for mental health or substance use services and suicide prevention pathways.	- Provide direct referrals for accessing emergency responses - Utilizes technology "air traffic control" routing, GPS locator and other data systems
Mobile Crisis Teams	A response system that utilizes behavioral health professionals to navigate within a region and at the scene of a crisis to complete mental health and substance use	- Work with law enforcement when needed and with appropriate protocols - Intervene as the crisis is occurring in any community setting - May provide follow up check-ins, wellness checks and other community-based interventions

	assessments or connect a person in crisis with services.	- Often designed for youth and adults through separate funding streams but may be linked
Crisis Intervention Teams (CIT)	Specially trained law enforcement officers who have undergone designated CIT training, adhere to policies for CIT officers and are linked to behavioral health designated crisis drop off points of access to care.	- More than just training, CIT programs are designed to improve police response and improve safety in dealing with individuals experiencing mental health crises - Can be successful in diversion of individuals with mental illness from the criminal justice system - Training emphasizes strategies for de-escalation and linkage to treatment - In addition to law enforcement training, the model includes partnering with drop off sites, robust community crisis care, behavioral health staff training, family, consumer and advocate involvement
Co-Response Teams	Coordinated behavioral health professionals and law enforcement teams who respond to emergency calls for emotional disturbances in the community together.	- May be embedded in police department staffing or may be worked out through protocol and funding with local behavioral health mobile crisis team - Practices involve simultaneous response and delineation of on the scene roles and responsibilities - Emphasizes diversion through on scene support, assessment and referrals rather than arrest
Crisis Hubs/Crisis Centers/Coordinated community crisis response center	Locations and systems that provide immediate in-person attention to any level of urgent to emergent need for mental health and substance use disorders and may include call centers, drop-in, and drop off sites.	- Includes virtual interconnected activities where the hub is through technology and routing - Allows walk-in clients in need of assistance and may provide urgent care assistance - Ideally offers combined management of substance use and mental health crises including withdrawal management and harm reduction strategies - Serves as drop-off center for law enforcement with the goal of diverting patients in a mental health crisis or with a substance use need away from the criminal or juvenile justice system - Manages crisis response across various community of crisis services - May manage calling centers to answer crisis calls
Psychiatric Urgent Care	Clinics with screening, assessment, brief intervention and prescribing capabilities that operate for walk-in visits with no appointment needed for immediate mental health and substance use support during day hours and limited weekends.	- Multidisciplinary staff including peers - Outpatient services and supports - Provide brief prescriptions - Withdrawal management and referrals - Provide linkages to longer term services
Transition or Bridge Clinics	Clinical therapeutic and medication management services made available for individuals moving from one level of care to the next (e.g., emergency department to long-term supports, or inpatient to community).	- Provide psychiatry access for medication prescriptions to avoid gaps in care while waiting for openings at regular outpatient services - Can be built to address medications and brief counseling to support opioid use disorder and other substance use needs
Crisis Stabilization Units (CSU) and	Brief, time limited (usually Up to 23 to 72 hours), medically monitored or supervised, observation units that	- Small facilities (less than 16 beds) for patients whose needs cannot be met in the community alone following a behavioral health crisis, sometimes licensed similarly

Extended Observation Units	provide care to assist with de-escalating the severity of a crisis and/or need for urgent care.	to inpatient units, sometimes licensed with separate regulatory schemes short of inpatient level of care - Provide prompt assessment, medical monitoring, stabilization and determination of next level of care needed - Considered less restrictive and an alternative to traditional inpatient psychiatric hospitalization - May allow for either voluntary and or involuntarily holds under mental health statutes similar to civil commitment provisions depending on state statutes and regulations - Involuntary medications usually only administered in an emergency context
Crisis Residential Services	Services where individuals in crisis can voluntarily reside for brief periods (usually up to 14 days) and receive behavioral health supports in a less intensive setting than inpatient level of care.	- Can be used as a step-down or diversion from an inpatient hospitalization - Can be used to assist in de-escalating a person's level of distress and/or need for urgent care associated with a substance use or mental health disorder by providing continuous observation and clinical support - Can include access to multidisciplinary treatment including treatment with medications and therapeutic supports
Living Room/Peer Run Crisis Centers	Comfortable non-clinical space that provides an alternative to emergency rooms for adults for short-term stays where individuals have available recovery support staff such as peers to help resolve crises.	- Provides a calming and safe environment - Short term stays (days to weeks)
In-Home Supports/Family-Based Crisis Home-Based Support/ Respite Services	Short-term intensively supported services where individual may stay with their own family or other qualified local family or provider-based locations with add-on supports.	- Includes regular contact and home visits with mental health professionals and other support staff, parent peers or mentors
Emergency Rooms with or Without Dedicated Behavioral Health Sections	Embedded hospital-based service for medical emergencies, including psychiatric emergencies, especially where safety related to psychiatric illness, medical management of substance use or medical co-occurrence may be an immediate concern.	- More appropriate when medical issues or uncertain diagnostic complexity need careful monitoring - More appropriate for severe drug use or alcohol use where medical monitoring is indicated - Increasingly able to induce medication assisted treatment for opioid use disorder - May be more appropriate for extreme behavioral dysregulation challenges
Partial or Day Hospitals	Community-based day mental health services with full multidisciplinary team with groups, therapies, medically monitored, and access to prescribers who can adjust medications while the individual resides at home.	- Appropriate for individuals with ongoing symptoms of mental illness but low safety concerns - Individuals typically sleep at home and come to hospital during daytime hours - May be used as a transitional treatment site when moving from inpatient to outpatient care

Acute Psychiatric Hospital Units	Hospital level of 24-hour care for psychiatric illnesses for a person who needs intensive, multi-disciplinary treatment with medically managed intensive and round-the-clock nursing, usually addressing safety and complex care-management needs.	- Typically, a locked setting - Typically, a length of stay days to weeks - May allow voluntary and involuntary patients - Treatments provide maximum diagnostic assessment, observation, medication adjustments, and address risk of harm to self and/or others - May allow ECT administration - Considered the highest medically necessary level of care - May be found in critical access hospitals as small facility that have 24-hour emergency care, outpatient and inpatient services - May be found in general hospitals, freestanding private, or, in some places, within state psychiatric hospitals still accepting acute patients

*Adapted from: *Crisis services.* National Alliance on Mental Illness; *Crisis services: Effectiveness, cost effectiveness, and funding strategies,* 2014, SAMHSA; Saxon V, et al. Behavioral health crisis stabilization centers: A new normal, 2018, *J Mental Health & Clin Psychology; National guidelines for behavioral health crisis care best practice toolkit,* 2020, SAMHSA; *Getting to the ideal behavioral health crisis system: Essential elements, measurable standards and best practices,* 2020 (draft under review), Group for the Advancement of Psychiatry. Centers for Medicaid and Medicare Services 1115 Waiver Definitions of Terms used in the Availability Assessment, 2020.

Figure 1: Flow of the Current Problematic Crisis System

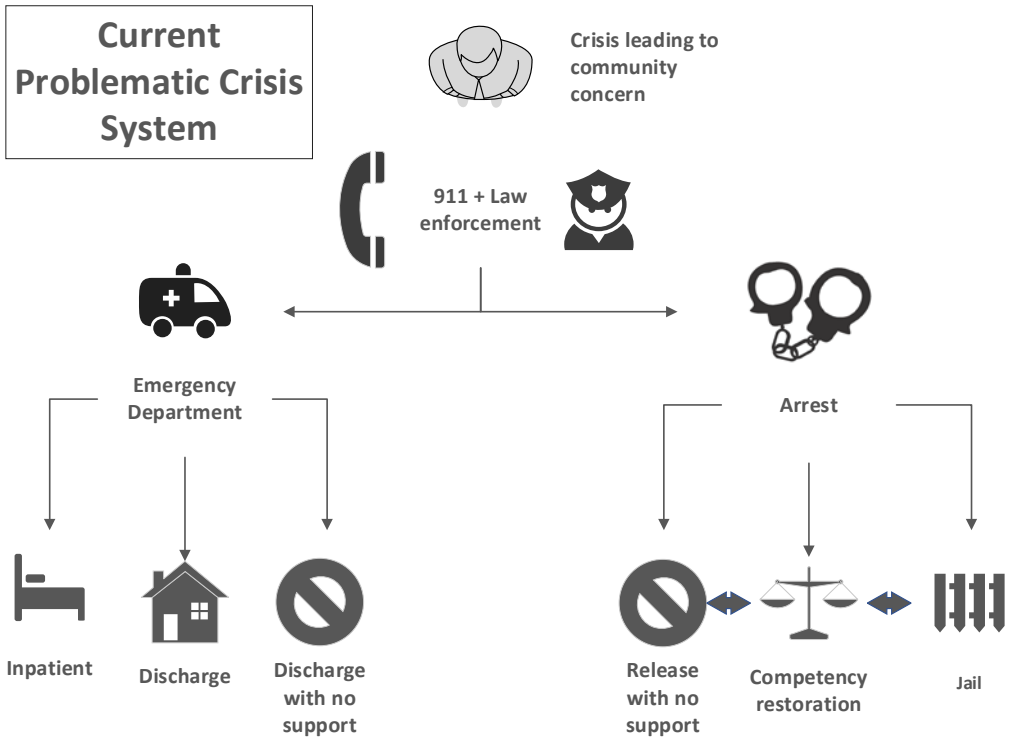
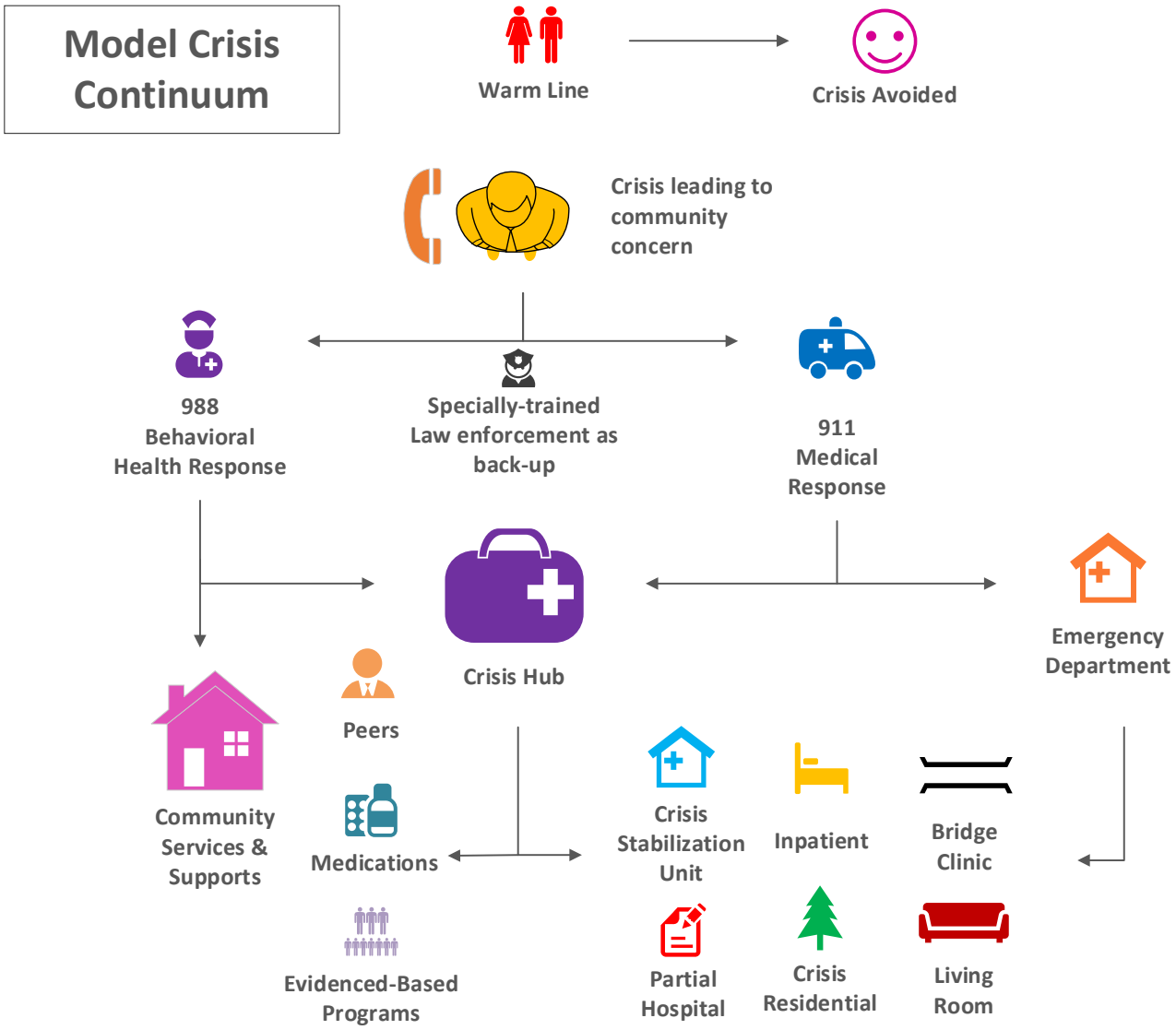


Figure 2: Flow of an Interconnected Model Crisis Continuum



Examples of Effective Crisis Services

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

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

Other types of supports are being built to help individuals access outpatient services outside of traditional models where there may be waits for appointments. For example, psychiatric urgent care clinics have opened, some inspired by demand and complexity related to COVID-19.[20] There are several on-demand mental health clinics available in Massachusetts,[21] and envisioning the continuum of tomorrow, advocates have called for same-day access while considering the challenges to funding services of this nature.[22] Even in addiction care there has been much done around the country to get immediate access to medication assisted treatments (MAT). The Certified Community Behavioral Health Clinics model also is setting forth a path given that the model requires easy access to care and 24/7/365 crisis services and is being examined as a model in various states.[23]

Pathways in Crisis Services

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

Beyond Beds

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

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

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

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

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

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

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

The Evolving Role of Law Enforcement and Mobile Crisis Responses

The Sequential Intercept Model, a framework for helping systems develop strategies to identify and intercept an individual with mental illness and/or substance use away from criminal justice involvement and toward treatment, expanded its focus to include examination of the crisis care continuum with the addition of "Intercept 0" in 2017.[33] The Department of Health and Human Services Assistant Secretary for

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

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

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

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

Beyond Beds

Recommendation #3: Criminal and Juvenile Justice Diversion

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

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

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

Models where behavioral health and law enforcement are designed to co-respond in some fashion also show promise and several have highlighted that consumer experience is positive.[46,47] An example of an effective police-based specialized mental health response is the Crisis Response Team in Seattle, WA.[48] Starting in 2010, the police department contracted with the local mental health agency to have mental health clinicians work directly with CIT officers. A qualitative study of the program found that the model improved encounters between law enforcement officers and people experiencing mental health crises as well as better utilizing police department resources.[49] In Massachusetts, the provider organization Advocates launched a co-responder model in 2003, partnering with the state Department of Mental Health and other stakeholders and has continued to grow across the state, showing successful outcomes for jail diversion, cost savings and shifts in police culture and attitudes about managing mental health crises by embedding a clinician in local police departments to ride with police and respond to crises[50] In addition to having specialized behavioral health staff assigned to work within local police departments to jointly respond to crises, they were able to leverage the entire mobile crisis service to help the communities they serve.

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

Beyond Beds

Recommendation #10: Partnerships

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

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

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

Person-Centered Crisis Care

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

SAMHSA Crisis Toolkit: Principles of a Crisis Service Continuum

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

One strategy to maximize individual voice in their care is through Psychiatric Advance Directives (PADs) (sometimes also referred to as Behavioral Health Advance Directives).[59] For crisis service providers, it is important to know if the individual has a psychiatric advance directive and then to understand what it means and how to honor it. The 1990 Patient Self-Determination Act codified the need to have certain healthcare facilities make patients aware of opportunities for advance directives. In the mental health area, these are legal documents that an individual executes typically during a period of wellness that codify their specific behavioral health treatment decisions that then could be enacted when their mental health deteriorates to the point where their decision-making is compromised.[60] Decisions might include determining a surrogate decision-maker who can help interpret the individual's preferences during a crisis. In addition, decisions that are spelled out might include authorizing or declining particular medications or somatic treatments (including electroconvulsive therapy) and preference for particular psychiatric hospitals, to name a few. Several resources are available to crisis service providers that provide further details about PADs (see for example, the Psychiatric Advance Directive Resource Center at https://www.nrc-pad.org/).[61] SAMHSA has also funded further information about PADs through its technical resource site for providers, individuals and family members dealing with serious mental illness at www.SMIAdviser.org. This resource site offers an app available for furtherance of individual psychiatric advance directives. Although some individuals who encounter psychiatric services may be under an assisted outpatient treatment court order or brought in by police,[62] PADs may be one strategy that can ultimately

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

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

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

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

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

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

The importance of having all staff trained appropriately on safety and security, as well as Zero Suicide principles is critical given that the crisis service itself can result in a critical lifesaving opportunity. Accessibility to medical services when needed should be part of proper linkage supports. The 2020 NASMPHD Series of technical assistance papers focused on *Beyond beds: Crisis Services* includes examination of crisis services for diverse populations including individuals with substance use disorders,[69] children and adolescents,[70] homeless

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

Supporting the Crisis Infrastructure, From Laws to Technology

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

Beyond Beds

Recommendation #4: Emergency Treatment Practices

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

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

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

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

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

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

Crisis Services During COVID-19 and Beyond

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

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

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

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

Conclusions

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

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

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

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

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Introduction and Methodology

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

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

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

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

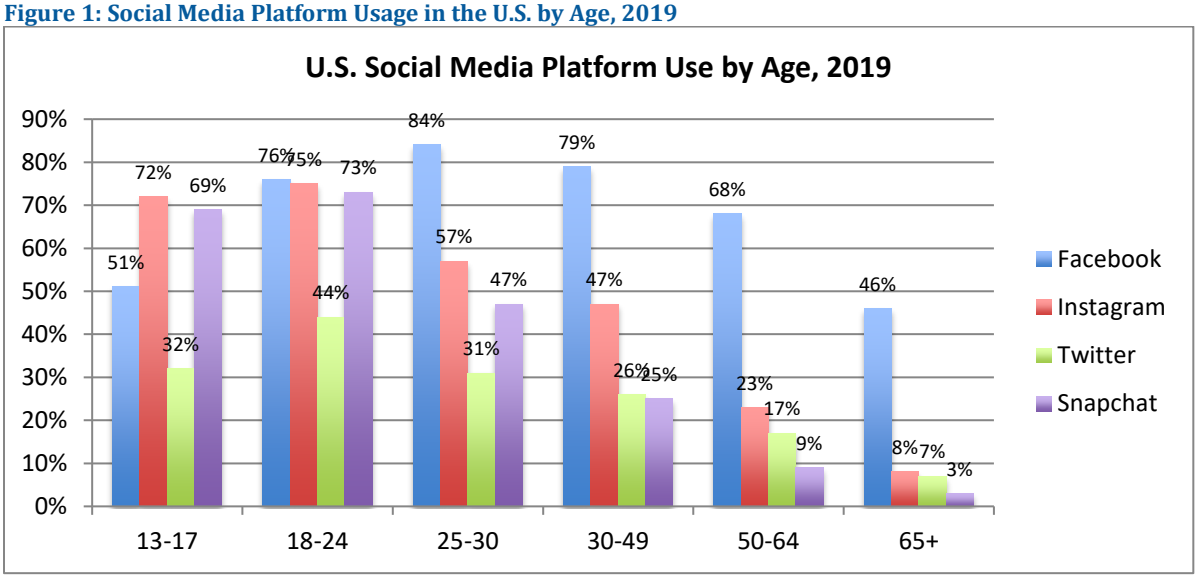
by the states, and the opportunities and challenges it presents, in the delivery of each of the three critical services identified in the *National Guidelines.*

Marketing Crisis Services through Digital Media

In order for people to seek out services during times of need, they must first be aware that services are available. While many traditional mediums exist to market the availability of behavioral health crisis services (e.g., television, radio, print publications, etc.), in the last decade, the use of social media has expanded rapidly and is an important tool to engage individuals of all backgrounds and ages, and can be especially effective in reaching youth and young adults. Engaging individuals at younger ages is important in providing prevention and early intervention services that may reduce the need for future crisis services, as "the onset of mental health problems peaks between adolescence and young adulthood".[4] States are investing in the use of social media to promote the availability of crisis services, and to help normalize the need for and use of behavioral health crisis services.

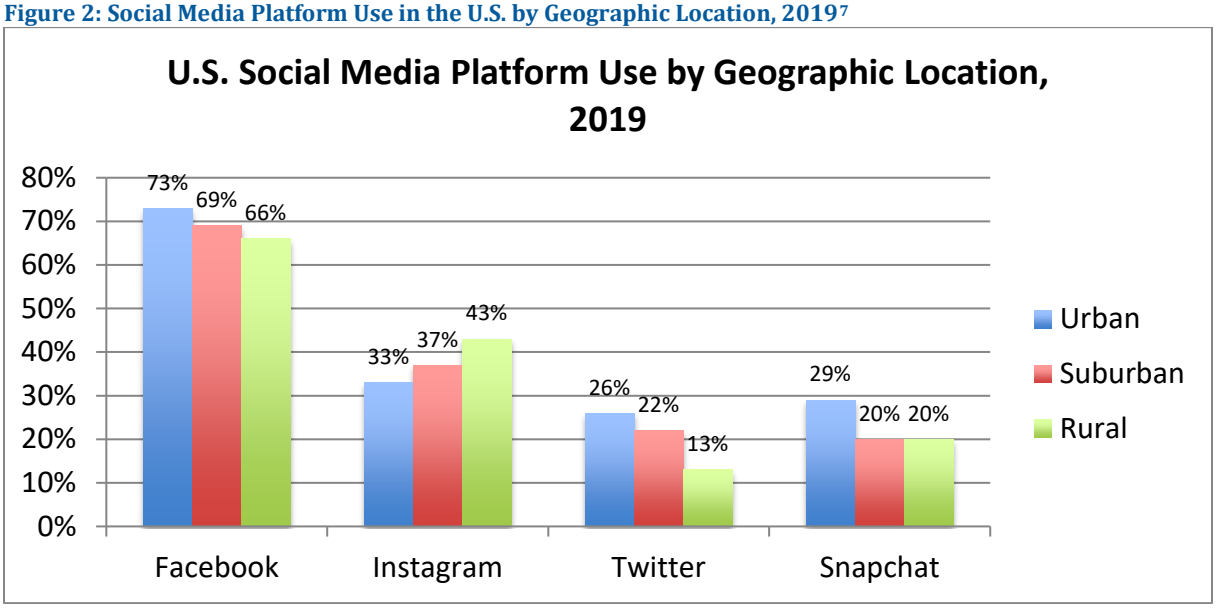
The social media platform a state uses should be determined by which age group and geographic location the SBHA is trying to reach. Facebook has the broadest reach among all age groups, with nearly 50% of all age groups using this platform. Snapchat and Instagram are more effective at engaging youth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

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



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

Figure 2: Social Media Platform Use in the U.S. by Geographic Location, 2019[7]



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

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

Using Technology to Improve Crisis Hotlines & Text Lines

The majority of SBHAs (82%) offer statewide or regional hotlines that are available 24 hours per day, seven days per week, 365 days per year.[9] However, the existence of a crisis hotline does not guarantee that people will use it, or that it is being used effectively. SAMHSA's *National Guidelines* recommends that, at minimum, states operate either regional or statewide crisis call centers that are fully staffed and

provide crisis intervention services and suicide risk assessments by trained professionals, coordinate callers with nearby mobile crisis teams, and conduct warm hand-offs to facility-based care when needed. Best practices for call centers create an "Air Traffic Control" model for hotlines, and include the incorporation of caller-ID technology, the use of GPS to efficiently coordinate care with mobile crisis teams, have access to a regional or statewide behavioral health bed registry to identify available and appropriate beds, and have the ability to schedule follow-up appointments to ensure ongoing care following a crisis episode.[10] Hotlines should also offer text and chat services to make the services more accessible.

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

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

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

Several states interviewed for this report noted that their states' centralized crisis hotlines operate in tandem with emergency/after-hour call lines sponsored by local community providers. This duplicative arrangement prevents maximum utility of a centralized state crisis hotline, and can serve to overburden local providers, especially in smaller, rural communities, which can lead to high levels of employee burnout and turnover. For example, a former provider from a remote village in

Alaska described a time when he was the only clinician available to answer and respond to crisis calls in the community during a six-month period. During this time, he had to constantly be available and in reach of his phone, even while trying to spend time with his family. While the actual number of crisis calls he received was low, he did experience many misdials. A centralized call center that is promoted and utilized across the state could help absorb some of these misdials and alleviate some of the pressure on providers, especially in rural areas where workforce issues prevail (Owens, Chipp, personal communication, July 1, 2020).

SMHAs may face barriers when establishing statewide crisis hotlines. It was noted during the interview with Colorado's Office of Behavioral Health that there is reluctance among both individuals in need of care and law enforcement officers in smaller communities to call into an anonymous state crisis hotline. The reluctance is fueled by a sense of resentment that someone "in the big city would actually know about my life and my problems" (Lee, personal communication, July 1, 2020). This can lead to more after-hour emergency calls to local community providers, when the Colorado Crisis Services Hotline could just as easily direct the caller to appropriate care and dispatch appropriate crisis services (Lee, personal communication, July 1, 2020). To encourage use of its statewide hotline, New Mexico's SMHA waived the state's unfunded requirement for local providers to operate their own emergency call capability. The only thing the SMHA required of providers was a memorandum of understanding with the statewide call center (Lindstrom, Wynn, personal communication, June 9, 2020).

Crisis Text Lines

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

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

primarily originated from the state's more urban counties, including Denver, El Paso, Arapahoe, Adams, and Jefferson Counties.[19] The Office of Behavioral Health makes available monthly reports showing the utilization of their text services throughout the state.

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

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

<u>Emotional Support Lines for Healthcare and Frontline Workers During COVID-19</u>

In addition to general behavioral health crisis hotlines and text lines, New Mexico established a dedicated support line for health and behavioral health providers, and other frontline workers who may be anxious and overwhelmed as a result of their positions in the context of COVID-19. New Mexico's Healthcare Worker and First Responder Support Line was established in response to the increased burden faced by frontline workers during COVID-19 pandemic (Lindstrom, Wynn, personal communication, June 9, 2020). New Mexico publishes detailed utilization reports monthly on its Crisis Line website.[iii] Utilization data are available for the Crisis Call Line, Support Line, Warm Line, and Core Service Agencies calls. Since its launch in May 2020, the support line has received 129 calls from healthcare workers and first responders.[20] Between May and June, 69.7 percent of these calls were related to COVID-19.[21] The support line is staffed by professional counselors with the New Mexico Crisis and Access Line. Figure 3 shows a flyer used to promote the New

[ii] A bot is a computer program designed to simulate a human interaction.
[iii] https://www.nmcrisisline.com/resources/public-awareness/

Mexico Healthcare Worker and First Responder Support Line. Tennessee also established a support line for healthcare workers working the frontlines of the pandemic; however, unlike New Mexico, Tennessee's support line is staffed by volunteers and does not provide clinical, medical, or therapeutic services.[22]

988: The Future of the National Suicide Prevention Hotline

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

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

National Crisis Text Line

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

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

response times and care for individuals texting in a crisis. Reports on utilization are available at www.crisistrends.org.

Using Technology to Improve Mobile Crisis Response

Mobile crisis response teams consist of mental health professionals who respond to behavioral health crises in the community at the request of first responders or crisis call lines. The *National Guidelines* recommend that mobile crisis teams be "available to reach any person in the service area in his or her home, workplace, or any other community-based location of the individual in crisis in a timely manner".[34] Using GPS technology, as described above, can improve response times by identifying the nearest available mobile crisis response team. However, many states interviewed for this report require teams to respond within two hours or more for those in rural areas, which can seem lengthy for an individual experiencing the crisis and for other first responders who are taken away from their normal service when waiting for a mobile crisis team to respond. Technology can be used to expedite response times, and remotely meet the needs of the individual in crisis. South Carolina and Colorado are implementing and exploring strategies that use technology to improve mobile crisis response and meeting people in the community where the crises are occurring.

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

county. This approach also reduces the need for mobile crisis teams to travel long distances to reach individuals experiencing a crisis, and allows individuals in crisis to receive services quickly. Since this program has been implemented, the county has experienced an increase in calls from EMS to mobile crisis from five to nearly 85 per month, and the county has seen a 58 percent decrease in ED use for individuals in psychiatric emergencies (Bank, Blalock, personal communication, July 7, 2020).

Colorado's Office of Behavioral Health (OBH) is considering a model similar to South Carolina's, but instead of deploying masters-level clinicians to respond to individuals in the community in crisis, it would rely on volunteer, trained citizens (often bachelor's-level clinicians or peer specialists) who carry tablets to virtually connect people in crisis to care. Colorado requires there be at least one mobile crisis response team that can respond to crises within two hours in each of the five regions of the state. While each region has met the minimum obligation for the number of teams, there are multiple mobile crisis response teams in urban areas, and only one serving the more rural and remote areas of the state, making it difficult for mobile crisis teams to adhere to the two-hour guideline. OBH has heard from communities in the more rural areas that they have concerned citizens wanting to help respond to crises, but do not know the most appropriate way to provide help. The state is exploring training these citizens, who are bachelor's-level providers or peers, to carry a tablet to an individual in crisis that can be used to connect the individual to a masters-level clinician via telehealth services. Unfortunately, the COVID-19 pandemic has delayed progress in these programs, and future budgetary decisions at the state level may determine the fate of these programs.

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

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

Using Technology to Improve Access to Crisis Receiving and Stabilization Facilities

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

Behavioral health bed registries are "regularly updated web-based electronic databases of available beds in behavioral health settings".[36] As of 2019, 19 states had active behavioral health bed registries.[37] To expand the availability of bed registries in the U.S., SAMHSA's Technology Transfer Initiative (TTI) 2017 grant funded 23 states to establish new or enhance existing behavioral health bed registries. A review of TTI state efforts shows that the most common type of beds included in a behavioral health bed registry are beds in crisis stabilization units (18 of 23 states). Bed availability data are most often updated twice per day (9 states), and are available primarily to authorized users (13 states), including participating hospitals, mobile crisis teams, emergency departments, local provider agencies, and call centers.[38] Bed registries implemented by the TTI states follow one of three models: search engines, referral systems, or referral networks (taken from the 2020 *TTI Crisis Bed Registry Report*, currently under review):

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

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

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

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

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

Beyond telehealth and telepsychiatry services, opportunities for the use of technology in crisis services are continuing to grow. Mobile and wearable devices, such as smart phones, tablets, and activity trackers (e.g., FitBit, Garmin, and Apple Watches), as well as advances in artificial intelligence offer new ways for individuals, clinicians, and researchers to access services, monitor symptoms, and research changes in both physical health indicators and social behaviors that may predict impending behavioral health crises.

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

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

Considerations

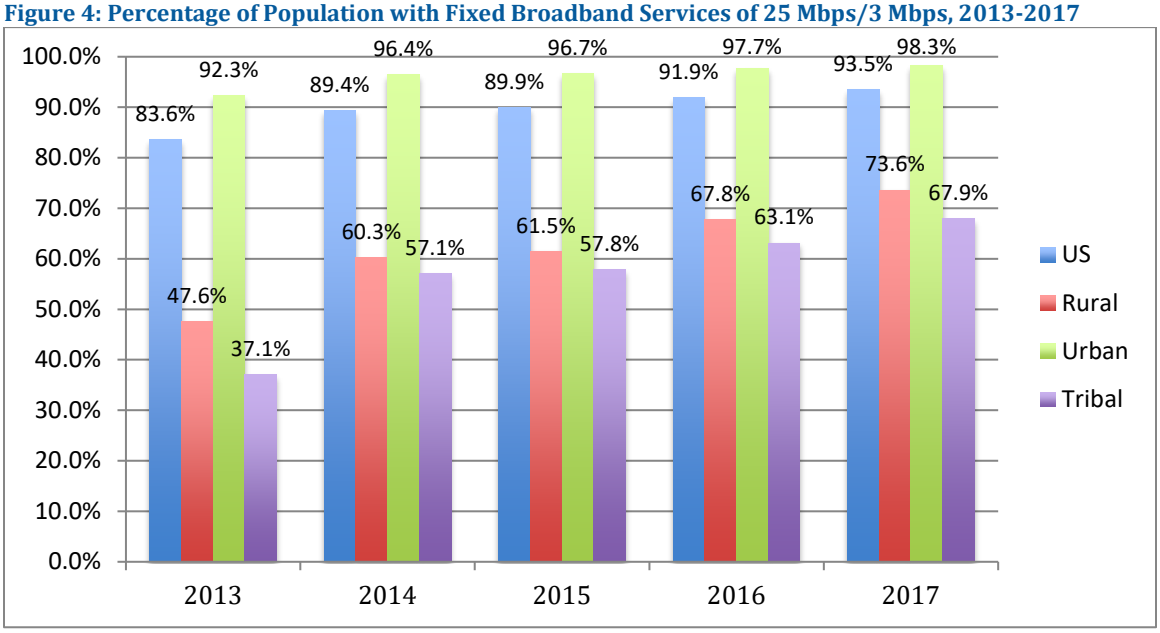
Technology offers much promise in improving access to behavioral health crisis care. However, when considering which technologies to implement, a variety of considerations exist that can influence the effectiveness, safety, and security of the technology in use.

Broadband Access

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

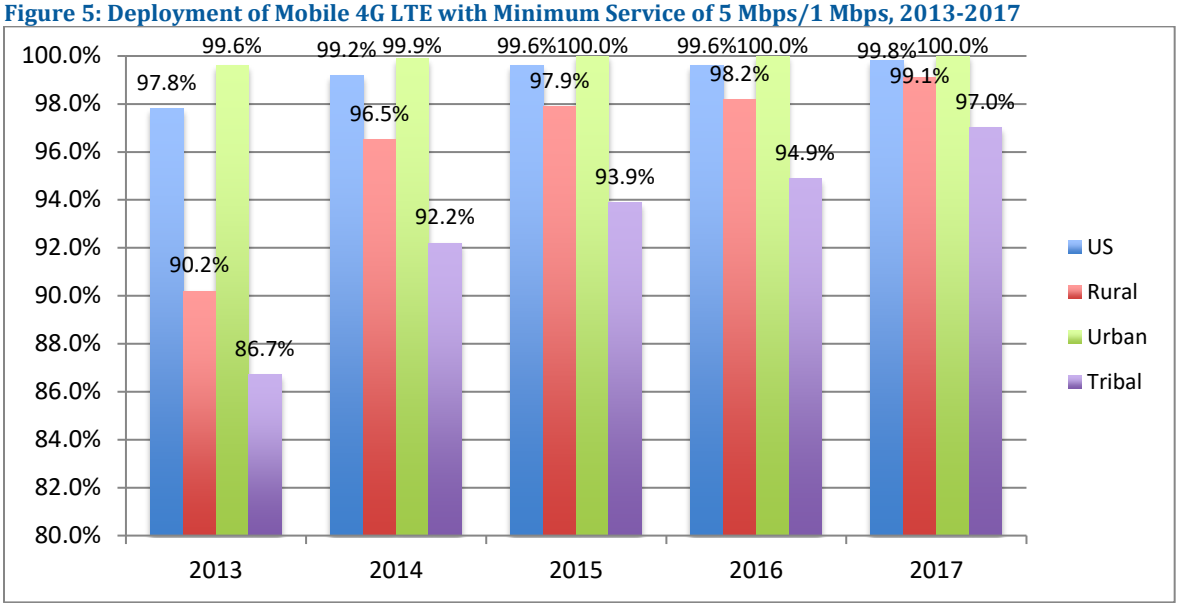
According to the Federal Communications Commission (FCC), the minimum fixed-broadband requirement is 25 Mbps download speed and 3 Mbps upload speed.[45] Data from the FCC show that this minimum level of broadband access has significantly expanded across all areas of the U.S., including rural and tribal areas, since 2013, although access in rural and tribal areas still lags behind urban connectivity. See figure 4.[46]

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



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

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



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

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

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

Financing

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

New Mexico's Behavioral Health Services Division was able to work with the state's Medicaid division to secure reimbursement for calls to the state's crisis line. However, callers must provide identifiable information, including their Medicaid enrollment status. Most call centers avoid this practice, as they want to ensure the anonymity of their callers. However, half of the callers to New Mexico's crisis line

[iv] FCC Connectivity Map available at https://broadbandmap.fcc.gov/#/

self-identified as being enrolled in Medicaid; therefore, the state was able to secure the 50 percent match on half of the callers, resulting in 25 percent of the call center's costs were subsidized by Medicaid. (Lindstrom)

Another challenge related to the implementation of telehealth services is that, prior to COVID-19, CMS stipulated that only specific providers were eligible to bill for telehealth services. In normal times, clinical psychologists and clinical social workers are not eligible to bill for psychotherapy services that include medical evaluations or management services. However, in response to the current pandemic, CMS has waived some of the requirements for billing. As of March 1, 2020, under the CARES Act, CMS now allows all Medicaid-eligible providers to bill for the provision of telehealth services, including masters-level clinical psychologists and social workers.[50] This flexibility allows states to better serve individuals and increases access to crisis care. Each state interviewed for this report expressed appreciation for the changes, and advocated making the changes permanent, beyond the public health crisis. Long-term strategies on the use of telehealth and who can deliver these services is an important consideration.

Privacy Concerns

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

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

Although they do not specifically offer crisis services, other technologies that promote mental health and wellness can serve as cautionary tales that underscore the need for strict security guidelines that adhere to "the core values of professional therapy [that include] strict confidentiality and patient welfare".[56] There is concern among researchers that some behavioral health and wellness apps "are corporate platforms first [and] offer therapy second".[57] Talkspace, launched in 2014, is an app that connects individuals through text and chat with a licensed therapist. is being scrutinized for "questionable marketing practices" and for treating client transcripts as data resources that can be mined to promote the services without concern for client confidentiality.[58] In addition, there is concern that private, for-profit companies such as Talkspace are driven by revenue, rather than concern for the wellbeing of their clients. A report by the New York Times found that Talkspace had employees write false reviews of the company to improve its ratings and encourage more sales, and "gave employees burner phones to help evade the app stores' techniques for detecting false reviews".[59] Of similar concern, a 2019 study released by Privacy International found that 76 percent of mental health websites in Europe, including those with depression screeners, would pass "answers and results of mental health check tests direct[ly] to third parties for ad-targeting purposes".[60] This indicates that these sites "treat the personal data of their visitors as a commodity," and do not "take the privacy of their visitors as seriously as they should".[61] Such deceitful practices can contribute to a feeling of uncertainty and a lack of trust in technologies that can effectively help people in crisis, inhibiting their use.

Efficacy and Safety of Technological Applications

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

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LEGAL ISSUES IN CRISIS SERVICES

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LEGAL ISSUES IN CRISIS SERVICES

Executive Summary Key Points

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

INTRODUCTION

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

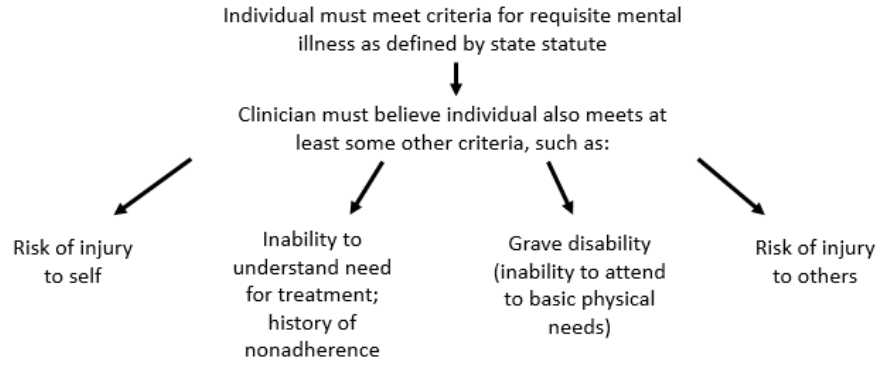
It is becoming increasingly clear that expanded crisis services are a critical part of the psychiatric care continuum for individuals and communities. Although they are important at any time, in the wake of recent events, such as various mass shootings, political unrest, and the COVID-19 pandemic, the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

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

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

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

Figure 1: Examples of Mental Illness Civil Commitment Criteria



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

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

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

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

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

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

THE ROLE OF GUARDIANS IN CRISIS SERVICES

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

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

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

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

RESTRAINT/SECLUSION IN CRISIS SERVICES

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

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

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

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

CONFIDENTIALITY AND DUTY TO PROTECT OTHERS IN CRISIS SERVICES

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

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

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

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

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

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

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

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

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

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

CRISIS CENTERS AND EMTALA

The Emergency Medical Treatment and Active Labor Act (EMTALA) was passed by the United States Congress in 1986.[57] The intent of EMTALA was to guarantee nondiscriminatory public access to emergency medical care regardless of an individual's ability to pay. This in turn was to prevent the practice of patient "dumping", defined as the "denial of or limitation in the provision of medical services to a patient for economic reasons and the referral of that patient elsewhere."[58] In short, EMTALA aimed to prevent hospitals from transferring patients who could not pay without consideration of their medical stability.[59] EMTALA requires all hospitals receiving Medicare funds to screen, examine, and stabilize a patient prior to a transfer taking place. In addition, EMTALA notes the receiving hospital must agree to the transfer and have facilities to provide the necessary treatment.

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

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

COVID-19 RELATED LEGAL ISSUES RELEVANT TO CRISIS SERVICES

COVID-19 has presented numerous challenges to health care systems around the world. While the medical complications related to COVID-19 are often prominently discussed, the mental health impact of COVID-19 also has critical bearing on individuals and communities. More than one-third of Americans noted that the COVID-19 pandemic was having a "serious impact" on their mental health, according to a survey by the American Psychiatric Association released March 25, 2020.[62] Given ongoing implications related to the global pandemic, providers of behavioral health services, particularly crisis services, should be cognizant of COVID-19 related mental health issues that they may be encountering in individuals presenting in a behavioral health crisis. Such issues include social isolation resulting from quarantines, economic and financial concerns secondary to lockdowns, and stress related to job-loss or food insecurity.

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

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

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

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

RISK MANAGEMENT AND LIABILITY WITH CRISIS CENTERS

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

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

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

CONCLUSION

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

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Strategies for the Delivery of Behavioral Health Crisis Services in Rural and Frontier Areas of the U.S.

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The Substance Abuse and Mental Health Services Administration's (SAMHSA) *National Guidelines for Behavioral Health Crisis Care* (referred to from here as "*National Guidelines*"), outlines the necessary services and best practices to deliver an effective crisis continuum. A comprehensive crisis service array includes three essential types of services: 1) centralized crisis lines that assess a caller's needs and dispatch support, 2) mobile crisis teams dispatched as needed in the community, and 3) crisis receiving and stabilization facilities that are available to "anyone, anywhere, anytime".[1] Data from the National Association of State Mental Health Program Directors Research Institute (NRI) indicate that nearly 98 percent of state mental health authorities (SMHAs) offer at least one of the crisis services recommended in the *National Guidelines*.[2] Of those, 82 percent of SMHAs offer 24-hour crisis hotline services, 86 percent of SMHAs offer mobile crisis response, and 90 percent offer crisis stabilization beds (either less-than 24 hours, or more-than 24 hours).[3]

While it is promising that the vast majority of states offer some level of crisis care to its citizens, it is unknown how widely available these services are, especially in rural and frontier areas, and whether they adhere to the best practices as prescribed in the *National Guidelines.* Ensuring all components are available to "anyone, anywhere, anytime" is an ambitious goal, and is especially challenging in rural and frontier areas where a lack of awareness, workforce shortages, distance to travel and transportation issues, cultural differences and the stigma associated with behavioral health, sustainability challenges, and availability of broadband internet services may present additional barriers to the delivery of comprehensive behavioral health crisis services in all locations.

According to the 2010 U.S. Census, 20 percent of the U.S. population, or approximately 60 million people, reside in rural and frontier areas of the United States, and their need for crisis services is comparable, or perhaps even greater, when compared to the need identified in urban areas.[4] Data from SAMHSA's 2018 National Survey on Drug Use and Health (NSDUH) show that 18.9 percent of adults aged 18 and older living in completely rural areas experienced a mental illness in the past year, compared to 18.6 percent of adults in urban areas.[5] 2018 NSDUH data also show that 2.5 percent of adults living in completely rural areas experienced a co-occurring substance use disorder and any mental illness in the past year, compared to 3.7 percent of adults in large metro areas.[6] Although rates of mental illness and substance use are comparable between rural and urban areas, the rates of serious mental illness (SMI) are higher in rural areas, with 5.8 percent of adults experiencing an SMI in the past year, compared to 4.1 percent of adults aged 18 and older in urban areas.[7] Additionally, while suicide rates among adults have risen since 2007 across the U.S., according to data from the Centers for Disease Control (CDC), the rate of suicide among individuals in rural counties increased at a rate 6.1 times faster than the rate in urban counties between 2007 and 2015.[8] Studies also show that youth in rural areas have nearly twice the risk for suicide than do their urban counterparts.[9] The divergence between suicide rates in rural and urban areas may be partially attributable to the prevalence of firearms in rural states, which

accounted for half of all suicides during the same period. Additionally, the availability of behavioral health services when in crises in rural and frontier areas is significantly limited when compared to urban areas. Multiple studies have shown a chronic shortage of mental health professionals in rural areas, and a tendency for providers to practice in more urban areas. These two factors underscore the need for a robust array of behavioral health crisis services in rural and frontier areas.[10]

The purpose of this paper is to understand the challenges associated with the delivery of comprehensive behavioral health crisis services in rural areas, and recognize the strategies and opportunities pursued by state authorities and local providers to enhance access and the availability of these important services in rural and frontier areas of the U.S. In addition, the opportunities and challenges presented by the COVID-19 pandemic are incorporated throughout.

A review of the literature was conducted to identify the most pressing challenges facing states and localities, as well as strategies used in the delivery of behavioral health crisis services in rural and frontier areas of the U.S. To ensure that only meaningful and relevant information is included, the author limited her research to include peer-reviewed journal articles and U.S. governmental reports published between 2010 and 2020. However, given the rapid advancements in technology, and the ever-changing needs and priorities associated with the COVID-19 pandemic, some news articles are referenced as well. To understand firsthand how these challenges affect the delivery of crisis services in rural areas and the strategies employed to overcome these challenges, the author and colleagues from the National Association of State Mental Health Program Directors Research Institute (NRI) and RI International conducted a series of seven structured telephone interviews with state, local, and non-governmental representatives from five states: Alaska, Colorado, Nebraska, New Mexico, South Carolina, and Tennessee (multiple entities from Alaska and Nebraska were interviewed for this paper). For the purposes of this report, the author relies on the U.S. Census Bureau's definition of rural, which is an area encompassing all population, housing, and territory with a population outside of an urban area with fewer than 2,500 individuals. The U.S. Census defines Frontier as an area with a population density of fewer than two people per square mile.[11]

This paper is divided into seven sections. The first five sections discuss the challenges and opportunities related to particular barriers to crisis service delivery in rural areas, including workforce, distance to travel and transportation, sustainability, and the use of technology and broadband access. These sections are followed by a section discussing additional effects the COVID-19 pandemic is having on the delivery of behavioral health crisis services in rural and frontier communities, and the implications each of these challenges and opportunities have for policy makers.

Behavioral Health Crisis Workforce in Rural Areas

As of September 2018, the Health Resources and Services Administration (HRSA) designated 2,672 Mental Health Professional Shortage Areas in rural areas.[12] The primary factor HRSA uses to designate Mental Health Professional Shortage Areas is "the number of health professionals relative to the population with consideration of high need," with a minimum of one provider to 30,000 residents (or 20,000 if there are higher than usual needs in a given community).[13] Data from the 2014 American Community Survey show that just 1.6 percent of the nation's psychiatrists practice in rural areas, which is on average nearly 47,000 residents per each rural psychiatrist.[14] Data from the American Medical Association show that nearly 60 percent of all counties in the U.S. do not have a single psychiatrist.[15] Compounding the issue is that many of the counties without a psychiatrist are clustered together, making it even more difficult for individuals to access psychiatric care quickly in case of an emergency.[16] Workforce shortages and retention issues were identified as a significant barrier to providing quality crisis care in each of the seven phone interviews conducted for this report. Several states, including Alaska and Colorado, are implementing or considering unique methods to reduce limitations to the delivery of behavioral health crisis services brought on by behavioral health workforce shortages in rural and frontier areas. Highlights of these unique methods are provided below.

<u>Alaska</u>

In the late 1960s, the Alaska Native Tribal Health Consortium (ANTHC) initiated the Community Health Aide Program to respond to the tuberculosis epidemic and the rise in infant mortality rates in tribal villages across the state. This program trained citizens with no experience in health care to provide basic health services and respond to the needs of individuals in rural and tribal areas across the state. The program was so successful that it was used as a model to implement the Behavioral Health Aide Program in 2008, which is a multi-level provider model that trains citizens on how to provide therapeutic services, respond to behavioral health crises, and support the general mental health and wellbeing of individuals in rural and tribal communities.[17] Support for the program was garnered through a number of newspaper articles and publications that recognized the significant mental health and substance use issues in the community, and noted that the state and local villages did not have adequate resources to respond to the need. (Owens, Chipp, personal communication, July 1, 2020).

Behavioral Health Aides (BHAs) are employed by their regional tribal health organizations; citizens interested in becoming a BHA need to be 18 years of age or older, and have earned a high school diploma or equivalent. There are four levels of BHA certification, including BHA-I, II, III, and Behavioral Health Practitioners. Potential BHAs often receive training from the ANTHC, who operates the only BHA Training Center in Alaska and works closely with the Community Health Aide Program Certification Board. Most training offered through the BHA Training Center are typically facilitated using a blend of distance-delivered technology; making the transition of courses that are usually held in-person relatively seamless

in response to COVID-19. Once certified, BHAs are qualified to provide and bill for various Medicaid services based on their level of certification, including SBIRT (Screening, Brief Intervention and Referral to treatment); tobacco cessation; and individual, group, and family psychotherapy. All BHAs are supervised by licensed clinicians who are able to assist BHAs in connecting individuals in crisis to higher levels of care, as needed (Owens, Chipp, personal communication, July 1, 2020).

BHAs are often the first to identify when someone is experiencing a crisis, and are the first to respond to traumatic events in the communities they serve. Alaska has found the BHA program to be effective at utilizing available human resources in communities that may otherwise not have an adequate supply, or any supply, of licensed behavioral health providers. BHAs serve multiple roles on the recommended crisis continuum, including answering emergency call lines and responding to crises in the community (similar to a traditional mobile crisis response team). These efforts help with the implementation of crisis services in rural and tribal areas. BHAs are notified of crises in the community in multiple ways, including a general awareness of crisis events in the community, monitoring patients and clients who have been identified as having serious mental illness, referrals that come through the general behavioral health department, collaboration with external behavioral health providers regarding aftercare needs for their clients who are returning home, or through referrals from Community Health Aides. To further highlight the essential role BHAs have in the continuum of care, Alaska's recently approved 1115 waiver clearly identifies BHAs as qualified provider types to deliver necessary services, including crisis response (Owens, Chipp, personal communication, July 1, 2020).

BHAs serve in multiple roles within the context of their position; this, coupled with the roles associated with being a member of a small community, can lead to high rates of burnout. During our interview with the ANTHC, it was noted that it is not unusual for BHAs to receive a "knock on the door at 2:00 am because they are known and trusted advisors in the community" (Owens, Chipp, personal communication, July 1, 2020). The multiple roles, the often indistinguishable boundaries between personal relationships and professional responsibilities, and the need to be constantly on-call to their communities can be confusing, exhausting, and lead to burnout, which ultimately leads to a high rate of turnover among BHAs. To reduce burnout and mitigate turnover, one of the largest tribal organizations in the state holds weekly teleconference calls specifically for BHAs to provide emotional support. During these calls, BHAs share stories to connect with and support one another, share traditional stories that connect to the types of cases they are serving and focus on their own wellbeing and mental health. (Owens, Chipp, personal communication, July 1, 2020).

The BHA program is financed through compact funding from the Indian Health Service (IHS), although the funding is limited. To increase resources to support the program, the ANTHC follows a fee schedule for courses delivered through the

ANTHC BHA Training Center for aspiring BHAs, and has applied for several grants to fill the gaps (Owens, Chipp, personal communication, July 1, 2020).

In July of this year, the IHS announced the expansion of the Community Health Aide Program, including the BHA program, to tribes in the contiguous U.S.[18] This effort will increase the ability of tribal communities that typically reside in rural and frontier areas to deliver physical health, behavioral health, and specifically behavioral health crisis services to individuals in their own communities. In addition to being available to tribes in the contiguous U.S., the Behavioral Health Aide Program makes available for a fee technical assistance to other communities interested in implementing a similar model.

Colorado

Currently Colorado requires there be at least one mobile crisis response team in each of the seven behavioral health regions of the state, and the teams need to be able to respond to a crisis within two hours of a crisis call. Each region has met the minimum obligation for number of teams; however, there are multiple mobile crisis response teams in the concentrated urban areas of the state, and only one crisis stabilization unit walk-in center and a few mobile crisis response team serving the entire Western Slope of the state, making it difficult for mobile crisis teams to adhere to the two-hour response guideline.

To improve crisis response times, Colorado is considering a model similar to, but less sophisticated than, the BHA Program in Alaska. The state has heard from communities in rural areas that there are concerned citizens who want to help respond to crisis situations, but they just do not know the most appropriate way to help. Rather than training citizens to be certified BHAs, the state is exploring training bachelor's-level providers or peers to carry a tablet to an individual in crisis that would be used to connect the individual to a skilled or licensed professional via telehealth services. Unfortunately, the COVID-19 pandemic has delayed any progress in these programs, and future budgetary decisions may determine whether these programs will be able to be established.

Distance to Travel and Transportation to Crisis Services

Distance to travel, limited or no public transportation, and a lack of infrastructure are significant barriers to individuals in need of crisis services. These factors also limit an individual's ability to access other behavioral health services and community supports that minimize the need for crisis services in the future. These barriers often result in long waits for mobile crisis teams to respond, reliance on first responders to transport individuals to care, and a reluctance to call for help in the first place. Also, when individuals have to travel far to receive appropriate levels of care, they are often removed from their communities, and forced to navigate their crisis alone, without the support of their families and friends.

As recommended in the *National Guidelines,* states can adjust their mobile crisis team response times to accommodate for geographic distances in rural and frontier

areas. In line with this recommendation, all of the states interviewed for this report indicated that they have relaxed their response-time requirements for mobile crisis teams when answering calls in rural and frontier areas. However, this does not change the need for an individual in crisis to receive a timely response.

Many smaller communities rely on their local law enforcement officers and other first responders to transport individuals experiencing a crisis to care. In all 50 states and the District of Columbia, police are authorized to initiate a psychiatric hold for an individual who appears to pose a risk to themselves or others.[19] However, this legal authority often creates an over-reliance on law enforcement to respond to crises, especially in rural and frontier areas where behavioral health workforce resources are limited. The *National Guidelines* recommend not involving police unless alternate behavioral health first responders are unavailable, "or the nature of the crisis indicates that emergency medical response (EMS) or police are most appropriate". [20]

An example provided by one state during the interviews for this report is that the state has an Emergency Protective Custody Statute that mandates officers bear the responsibility for deciding if someone meets the criteria for immediate harm to self or others. In these instances, officers may have to transport an individual more than two hours one way to make sure they are admitted into treatment. Because of legal issues and risks of harm to the officer and individual, the individual being transported must be restrained and transported in the back of the locked police car. This approach can create stressful situations for an individual in crisis that can exacerbate their symptoms, and serve to drain the resources of small law enforcement agencies in rural communities.

An electronic behavioral health bed registry that can be accessed online is helpful to individuals and law enforcement in rural areas when they need to access higher levels of care. A bed registry can be used to identify an appropriate nearby available inpatient psychiatric hospital bed. This will avoid a situation where a person might be turned away after traveling a long distance when a bed is not available at a crisis stabilization unit. Through its Technology Transfer Initiative (TTI) project, SAMHSA is currently funding 23 states to establish or enhance crisis bed registries to reduce this barrier.

Alaska, Colorado, and South Carolina shared their experiences about the impact transportation barriers have on their delivery of crisis services, as well as some of their unique approaches to overcome these barriers to effectively deliver crisis services to individuals in rural and frontier areas.

<u>Alaska</u>

An extreme example demonstrating the effect transportation barriers have on the accessibility of behavioral health crisis services is the lack of available transport for individuals experiencing a psychiatric emergency in remote areas of Alaska. Many of Alaska's villages rely on ferries, airplanes, and seaplanes paid for by the SMHA to

transport individuals experiencing a behavioral health crisis to a designated evaluation team. Alaska's SMHA funds an on-call staff, available 24 hour a day, seven days a week to secure transports with contracted providers who are specially trained in transporting individuals in crisis. In addition, the SMHA funds all costs of transporting individuals to Designated Evaluation and Treatment (DET) hospitals. Transportation delays are also caused due to inclement weather and the challenges of getting in or out of Alaskan villages. Due to COVID-19 and the challenges associated with commercial airlines availability, the SMHA has funded an increasing number of private charters to bring individuals in crisis into a DET as soon as possible.

Prior to the COVID-19 pandemic, the SMHA relied on two airlines, Alaska Air and RavnAir, to transport individuals in rural, frontier, and remote areas to receive appropriate care (McLaughlin, Raymond, Girmscheid, personal communication, June 22, 2020). Since Marcy 2020, Alaska Airlines has significantly reduced flights, and has begun laying off employees in August 2020. The state's other airline, RavnAir has also been significantly affected by the current pandemic. RavnAir experienced a 90 percent decline in bookings and revenue resulting from the COVID-19 pandemic, which forced RavnAir into bankruptcy in April 2020, limiting the available transport options for individuals experiencing a mental health crisis, and exacerbating the inequities in access to mental health services during the pandemic.[21] Alaska's Medicaid plan does not reimburse for expenses related to transport for a psychiatric emergency (McLaughlin, Raymond, Girmscheid, personal communication, June 22, 2020). The SMHA staff noted that even when two airlines were available to transport individuals experiencing a psychiatric emergency, it would often take several days to arrange for air transport from the remote villages. This is in stark contrast to when someone needs transport for a physical health emergency funded by Medicaid, when air transport would be arranged within hours. This barrier may lead to individuals who are deemed a risk to themselves or others being boarded in less-than-appropriate settings, including local jails because other treatment options (e.g., crisis stabilization units) are unavailable, until they can safely be transported to an appropriate level of crisis care.

<u>Colorado</u>

To reduce the reliance on law enforcement to transport individuals to crisis stabilization or other inpatient facilities, Colorado proposed legislation to pilot a program to train and certify members of the community in rural areas to become secure transport drivers. The proposed program would be sponsored through a partnership between the state's Medicaid authority and the public utilities commission. The program would train drivers in de-escalation techniques, and would use funds to secure and enhance a fleet of vehicles to make them safe for drivers to transport individuals in crisis. Unfortunately, funding for this pilot program in two rural areas of the state has been cut due to budget cuts resulting from COVID-19; however, one program has been allowed to continue in southeast Colorado after a provider and the Administrative Service Organization reallocated budgets to allow it to continue.

South Carolina

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

Cultural Differences and Stigma Associated with Behavioral Health

According to a study out of Wake Forest University, the most commonly reported barrier to treatment among individuals in rural areas is the personal belief that "I should not need help".[22] Additionally, it is easier to seek help anonymously in large urban areas. According to Dennis Mohatt, the Vice President of the Behavioral Health Program and Director of the Western Interstate Commission for Higher Education (WICHE), "your neighbors don't have a clue in a city if you're going to get some help. But everybody [in a small town] will know if your pickup truck is parked outside of the mental health provider's office." Nebraska's Region 3, as well as Alaska's BHA program echoed this sentiment.

In the community served by Region 3, which consists of 22 primarily rural counties, there is a mindset among the farming and ranching communities that "you get back on the horse," and that whatever is bothering you will pass and is not something to take seriously (Reynolds, personal communication, June 17, 2020). This lack of awareness of mental health issues, as well as the stigma associated with serious mental health conditions, including depression, is reinforced by the primary care physicians serving in the area who often do not evaluate for or diagnose symptoms

of depression. Within the community there is a disconnect between the physical and mental health symptoms of the body that leads to a lack of mental health diagnoses and referrals to appropriate treatment. When these symptoms are overlooked for too long, in the worst cases they can lead to higher rates of suicide. Compounding the stigma in these communities, suicides are often not reported by the medical examiner as a cause of death on death certificates. Rather, death certificates indicate cause of death as a car accident or accidental overdose so as to not bring embarrassment to the family of the deceased (Reynolds, personal communication, June 17, 2020).

To combat this stigma, representatives from the Region often present at conferences for young ranchers. During these presentations, Region 3 staff share information about behavioral health and wellbeing, and promote the availability of behavioral health and crisis services in the area.

Additionally, the recommendations for centralized crisis hotlines made in the *National Guidelines* may also be more difficult to implement in rural areas due to beliefs in rural communities that people in the city would have no way to relate their problems. A study by the Pew Research Center found that "many urban and rural residents feel misunderstood and looked down on by Americans living in other types of communities [and that] people in other types of communities don't understand the problems people face in their communities".[23] This affects the use of the centralized crisis hotline in Colorado by individuals in rural and frontier areas.

During the phone interview with Colorado's Office of Behavioral Health, it was noted that there is reluctance among both individuals in need of care and law enforcement officers in smaller communities to call into an anonymous state crisis hotline number. The reluctance is fueled by a sense of resentment that someone "in the big city would actually know about my life and my problems? Why do they think they can fix this?" This leads to more after-hour emergency calls to local community providers, which are often already overburdened, when the Colorado Crisis Services Hotline could just as easily direct the caller to appropriate care and dispatch appropriate crisis services (Lee, personal communication, July 1, 2020).

Higher utilization of the centralized hotline can relieve the pressure of rural providers who are already overburdened with other responsibilities. During the interview with the ANTHC, a former provider in a remote village shared his story about being the only clinician available to answer crisis calls in the community during a six-month period. During this period, he had to be constantly available and in reach of his phone, even while trying to spend time with his family. While the actual number of crisis calls he received was low, he did experience many misdials. A centralized call center that is promoted and utilized across the state could help absorb some of these misdials, and alleviate some of the pressure on rural providers.

To encourage the use of the statewide hotline, New Mexico waived the state's unfunded requirement for local providers to operate their own emergency call capability. The only thing required of the providers is a memorandum of understanding with the statewide call center (Lindstrom, Wynn, personal communication, June 9, 2020).

Sustainability

Crisis services in rural and frontier areas face sustainability challenges in order to provide quality crisis care to "anyone, anywhere, anytime," when the population size and demand for services may not fully support the overhead and staffing requirements of the programs, especially for crisis receiving and stabilization facilities.

Many states fund their crisis services with state general revenue funds, especially for those services provided in rural and frontier areas of the state. Prior to its implementation of the Medicaid Section 1115 waiver, all of Alaska's crisis services were paid for through state general revenue funds and funds from the Indian Health Service for services provided to tribal villages (McLaughlin, Raymond, Girmscheid, personal communication, June 22, 2020). Even with the new Medicaid Section 1115 waiver for crisis services, the state will continue to rely on general revenue funds for building infrastructure and supplementing costs of care that cannot be covered by Medicaid (McLaughlin, Raymond, Girmscheid, personal communication, August 4, 2020).

Tennessee approaches this challenge by implementing a "firehouse model" to fund services provided by mobile crisis teams and crisis stabilization units. In this approach, crisis services are paid for on a per-member, per-month basis, based on the number of members in a particular catchment area at the time rates are established, not based on the number of people receiving services. Thus far, it has allowed for the sustainability of crisis services in rural areas of the state.

The changes implemented by the Centers for Medicare and Medicaid services in response to the COVID-19 pandemic have been incredibly helpful to states in providing crisis services to individuals in rural and frontier areas. A lack of broadband access in these areas limits an individual's ability to connect remotely to telehealth services, creating a greater demand for telephonic interventions, which are typically not reimbursed by Medicaid. However, as of March 1, 2020, under the CARES Act in response to COVID-19, CMS has waived the requirements for video technology and now allows the use of audio-only equipment to furnish a variety of services described under 42 CFR § 410.78(a)(3).[24] In addition to the flexibility for telephonic interventions, CMS has also relaxed some rules related to the qualifications an individual needs to be reimbursed for telehealth services. Prior to the emergency declaration, only certain providers were able to bill Medicaid for the provision of telehealth services. During the emergency declaration, all providers eligible to bill Medicaid for their professional services may now also bill for the telehealth services they provide.[25]

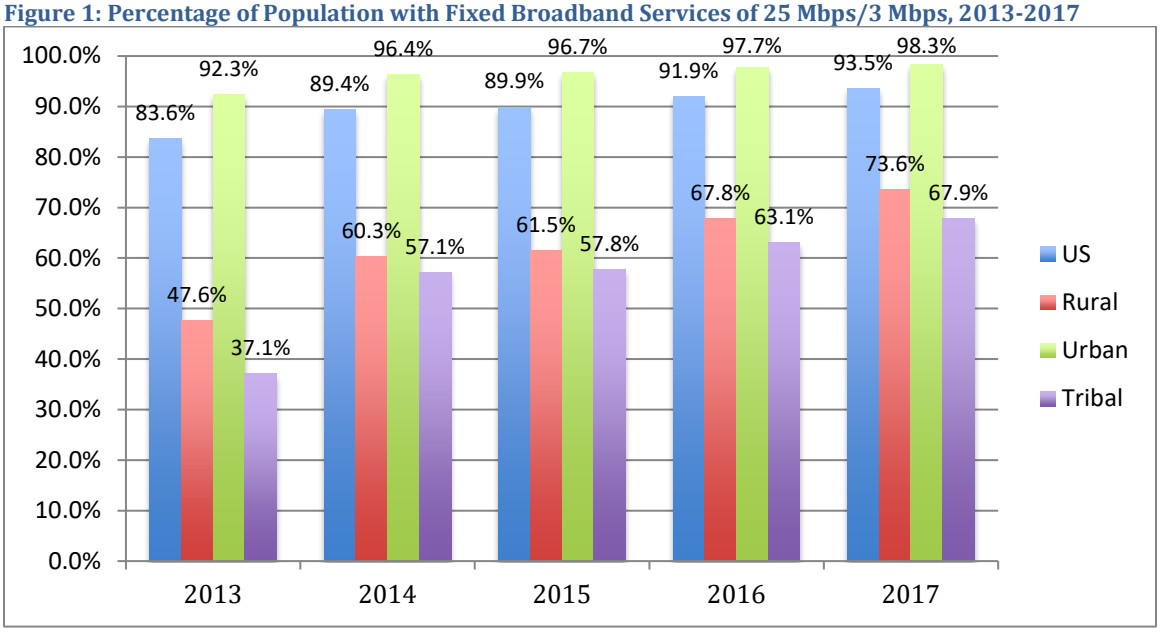
These flexibilities allow states to better serve individuals in rural and frontier areas, and increase access to crisis services for these populations. Each state interviewed for this report expressed appreciation for these changes, and advocated they be made permanent, beyond the public health crisis.

Use of Technology and Broadband Access

As described in the sections above, technology offers exciting opportunities to deliver sustainable crisis services to individuals in rural and frontier areas of the U.S. However, the infrastructure to support these methods is often lacking in less densely populated areas of the country. Inconsistent broadband connectivity in rural and frontier areas was identified as an area of need during each of the seven phone interviews conducted for this report.

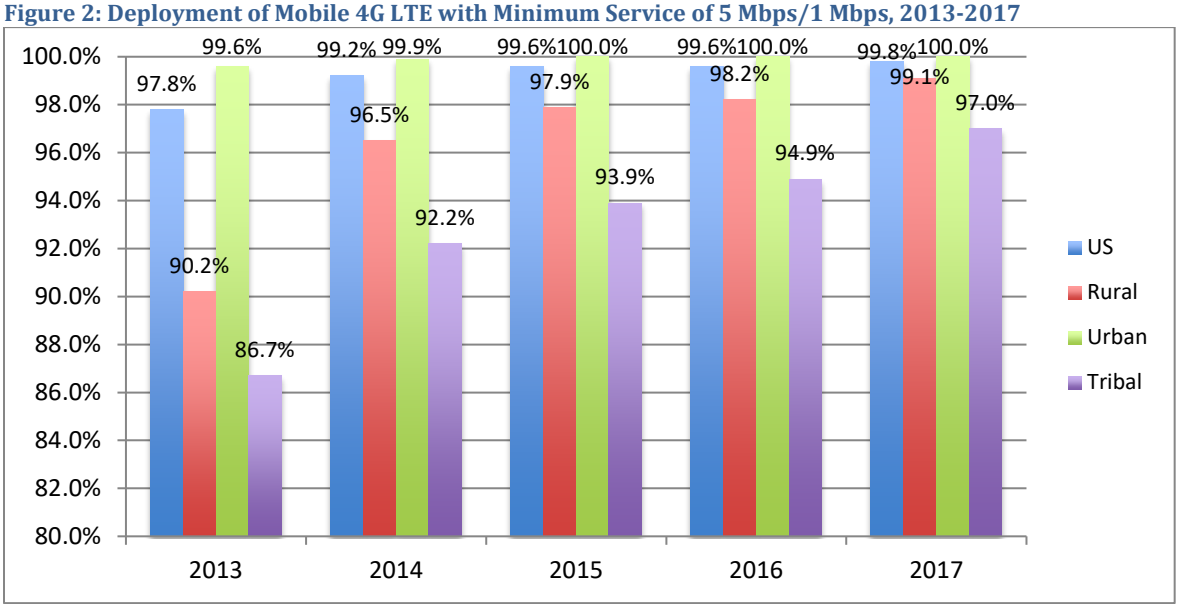
According to the Federal Communications Commission (FCC), the minimum fixed-broadband requirement is 25 Mbps download speed and 3 Mbps upload speed.[26] Data from the FCC show that this minimum level of broadband access has significantly expanded across all areas of the U.S., including rural and tribal areas, since 2013, although access in rural and tribal areas still lags behind urban connectivity. See Figure 1.[27]

Figure 1: Percentage of Population with Fixed Broadband Services of 25 Mbps/3 Mbps, 2013-2017



In addition to calculating rates of fixed broadband availability across the U.S., the FCC also monitors the availability of cellular technology. The minimum performance benchmark for mobile services is 4G LTE, within minimum speeds of 5 Mbps download, and 1 Mbps upload.[28] This level of mobile access is more widely available across all areas of the U.S., including rural and tribal areas, than fixed broadband services. See Figure 2.[29]

Figure 2: Deployment of Mobile 4G LTE with Minimum Service of 5 Mbps/1 Mbps, 2013-2017



While broadband connectivity, both fixed and mobile, is improving, and appears to be available throughout both rural and urban areas of the U.S., the experiences of individuals living in these areas may not align with the information available from the FCC. According to a 2018 Bloomberg report, the FCC's connectivity map (available online[i]), which maps the availability of broadband access by address, is inaccurate because it relies on Census blocks to calculate connectivity at a given address. Within Census blocks, which tend to cover small areas in urban communities and large tracts of land in rural areas, the availability of broadband can vary quite a bit. According to the report, "just because your closest neighbors have broadband doesn't guarantee you'll have any".[30] While the FCC purports that 21.3 million Americans lack access to broadband connectivity, research from BroadbandNow estimates that the number of Americans without broadband access is closer to 42 million, when taking into account the disparities within Census blocks.[31] The FCC data also do not consider limitations accessing broadband services due to the associated costs, and inability of some individuals to afford these services.

Not only does a lack of reliable broadband access limit the availability of telehealth services in rural and frontier areas, it also affects the perception of safety of mobile crisis response teams in rural and frontier areas. As discussed above, there are not enough mobile crisis teams to serve the entire Western Slope in the State of Colorado. This geographic area has mountainous terrain and can experience significant weather events, especially in the winter. Mobile crisis response teams are often reluctant to travel in these conditions, especially at night, when connectivity may be unavailable or inconsistent. To reassure members of the

[i] The FCC's Connectivity Map is available online at https://broadbandmap.fcc.gov/#/

mobile crisis teams that they should be able to reach help, should it be needed, the Office of Behavioral Health is sharing a map of broadband and cellular coverage with the mobile crisis teams. Additionally, mobile crisis teams across the state are exploring the idea of setting up mobile crisis "pop-up shops" in grocery stores and libraries in communities with better broadband coverage. The mobile crisis teams market to individuals that they can meet them closer in the community than an individual would have to travel to reach a crisis stabilization unit, while utilizing available broadband services. While this is not a perfect solution because the mobile crisis teams are not meeting individuals where the crisis is occurring, it is a compromise to help maximize the safety and wellbeing of the community, and sense of security of the mobile crisis teams.

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

Other Effects of COVID-19 on Crisis Services in Rural & Frontier Areas

The COVID-19 pandemic has restricted state budgets to pursue innovative programs, such as the transportation program and citizen response program in Colorado. It has also reduced the availability of transportation services in Alaska through decreased availability of air transport, compounded by the bankruptcy filing by RavnAir. In addition to these limitations, COVID-19 has also forced the closure or delayed opening of critical crisis services in rural and frontier areas of the U.S.

South Carolina's SMHA indicated that while mobile crisis response services did not cease during the pandemic, the state did have to temporarily close one crisis stabilization unit because the building is small and the space is not conducive to social distancing. Given utilization rates of other crisis stabilization units in the state, it is likely that demand for this unit would have increased during the pandemic; the crisis stabilization unit in Charleston experienced three times as many walk-ins between May and June than it had in previous years. Prior to COVID-19, South Carolina planned to expand its crisis stabilization services in four additional counties; however, the pandemic has delayed these efforts, and future progress is unknown due to budgetary restraints. Hospitals in the four counties where the crisis stabilization unit program was set to expand are funding partners of the initiative; however, given the financial hardships hospitals are facing as a result of the pandemic, they may no longer be able to financially support this initiative.

In Alaska, BHAs have realized an increase in demand for services since the COVID-19 pandemic began, because reportedly, baseline symptoms of anxiety among community members has increased, particularly in smaller communities that may not have centralized water and sanitation, and for those who have multi-

generational families living in one home. When COVID-19 began to spread across the U.S., many villages completely closed their borders to the rest of the state, allowing no transportation in or out, with the exception of cargo deliveries. Borders were closed, in part, due to historic trauma caused by the 1925 diphtheria outbreak and tuberculosis epidemic that decimated the populations of small villages (McLaughlin, Raymond, Girmscheid, personal communication, August 4, 2020). This isolation not only raises the collective feelings of anxiety of the community, but also limits the ability to access necessary care, unless robust telehealth services are available.

In addition, the COVID-19 pandemic has served to further exacerbate health disparities between rural and urban areas, which can heighten anxieties further in the face of a pandemic. Rural communities are disproportionately affected by an array of serious health issues, including heart disease, cancer, and stroke, which put individuals at higher risks of significant health consequences brought on by COVID-19, and can further strain limited resources in rural hospitals and health facilities.[32]

Implications for Policy Makers

Although the majority of states offer at least one of the recommended crisis services prescribed in the *National Guidelines,* it would be prudent for SMHAs to review where these services are available, and whether or not they meet the best practices guidelines recommended for their implementation. Based on the interviews for this report, although many states offer statewide crisis hotlines, they may not be used effectively in all areas of the state, especially rural areas, and most states do not use GPS technology to efficiently identify geographic location and dispatch the nearest support. Most states also provide mobile crisis response teams and crisis receiving and stabilization facilities; however, in many states these services are concentrated in urban areas, resulting in extended travel and wait times for individuals in need in rural and frontier areas of the states. States should also consider implementing an electronic bed registry system, if one is not already available, to facilitate access to available psychiatric inpatient and other treatment beds that provide appropriate levels of care closest to an individual's home. An evaluation of a state's crisis system could identify areas where additional services are needed and improvements can be made. The need for expanded promotion of these services was also identified. A review of service utilization could help SMHAs identify areas to more effectively promote their behavioral health crisis services.

The COVID-19 pandemic has highlighted the inequities between the delivery of crisis services in rural and frontier areas and urban areas of the U.S., and the related budget cuts faced by states are forcing the postponement or elimination of innovative programs designed by states to better serve individuals in rural and frontier areas. However, the pandemic has also served to underscore the need for broadband to access telehealth services and has identified opportunities for sustainable telehealth expansion. Behavioral health policy makers have an opportunity to unite with other stakeholder groups (including education and physical health) to advocate for expanded broadband coverage in rural areas.

Following the current emergency health crisis, states should work with CMS to make permanent some of the flexibilities afforded to providers in the delivery of telehealth services during the pandemic.

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Title: Cops, Clinicians, or Both? Collaborative Approaches to Responding to Behavioral Health Emergencies

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Abstract

How a community responds to Behavioral Health (BH) emergencies is both a public health issue and social justice issue. Individuals in BH crisis often receive inadequate care in emergency departments (EDs), boarding for hours or days waiting for treatment. These individuals account for a quarter of police shootings and over 2 million jail bookings per year. Explicit and implicit bias magnify these problems for people of color. Growing bipartisan support for reform provides an unprecedented opportunity for meaningful change, but solutions to this complex issue will require comprehensive systemic approaches. As communities grapple with BH emergencies, the question isn't *whether* law enforcement (LE) should respond to BH emergencies, but rather *when*, *how*, and *with what support*. This policy paper reviews best practices for law enforcement (LE) crisis response, outlines the components of a comprehensive continuum of crisis care that provides alternatives to LE involvement and ED utilization, and provides strategies for collaboration and alignment towards common goals. Finally, policy considerations regarding legal statutes, financing, data management, and stakeholder engagement are presented in order to assist communities interested in taking steps to build these needed solutions.

Defining the Issue

Healthcare and criminal justice systems are facing increasing challenges from the growing numbers of individuals experiencing behavioral health (BH) crises (defined here as a crisis related to mental illness or a substance use disorder).[1, 2] Unfortunately, there are few options available for a person in crisis. Law enforcement (LE) agencies, emergency departments (EDs), jails, and prisons have become the safety nets, yet they are not equipped to provide the care that these individuals desperately need.

Unlike medical emergencies, BH emergencies often result in a LE response. BH emergencies constitute between five to fifteen percent of all calls to 9-1-1 systems.[3] Adverse and sometimes tragic outcomes are all too frequent. It is estimated that a quarter of police-involved shooting deaths are linked to mental illness, half of which occur in the person's own home.[4] Over 2 million people with serious mental illness are booked into jail each year, often for non-violent "nuisance" or "quality of life" crimes such as loitering or vagrancy. Not surprisingly, the prevalence of mental illness and substance use disorders in jails and prisons are three to four times that of the general population.[5, 6] Once in jail, people with mental illness are incarcerated twice as long, and few receive needed treatment.[7, 8, 9] Upon release, with Medicaid benefits interrupted and a criminal record, they are more likely to be unemployed, homeless, and rearrested.[10, 11, 12, 13] Then the cycle continues.

Explicit and implicit bias magnify these problems for people of color. African Americans are 2.6 times more likely to be killed by police than non-Hispanic Whites; when combined with mental illness, this difference is nearly ten-fold.[14] For those struggling with substance use disorders, disparate sentencing penalties (e.g., harsher sentences for crack vs. powder cocaine) result in excessive imprisonment of Black Americans.[15] These long-standing inequities have been underscored by the continued high-profile killings of unarmed people of color by LE. Reducing racial inequities in crisis response and in access to BH care must be a central focus of any reform efforts.

The status quo negatively impacts LE as well. State civil commitment laws often prevent more appropriate responses to persons in crisis by requiring LE officers to conduct involuntary mental health transports. The lack of easily accessible treatment makes these transports time consuming and frustrating for officers.[16] A recent survey of LE agencies in the U.S. estimated the nationwide cost of transporting people with severe mental illness is $918 million annually. Law enforcement leaders also expressed dismay at the inhumanity of criminalization as a result of their role and concerns that the time spent on this function may restrict their ability to uphold public safety.[17] Police violence takes a toll on the officers too, with high rates of trauma and more suicides per year than line-of-duty deaths.[18]

As social movements for racial equality gain prominence, calls for fundamental policing reforms have gained traction and become more politically viable. This presents an unprecedented opportunity to rethink current approaches to people in BH crisis. While some call for "defunding" of the police in lieu of clinician first-responders, this will not eliminate the need for LE completely. Some BH emergencies may not become apparent until after officers are on scene for another issue. Other situations may pose an unacceptable amount of safety risk to civilian clinicians. Solutions will require broad systemic approaches with collaboration between LE and the healthcare system to create the optimum response for different types of cases, some of which may involve an LE response, a clinician response, or a co-response with shared responsibility.

For any response to be successful, the responders—whether LE or clinicians—require a functioning BH crisis system that can quickly accept individuals in crisis and provide the care they need. The solution is not simply to build more inpatient psychiatric beds any more than building more dialysis centers is the solution for gaps in diabetes care. Rather, communities must commit to investing in a coordinated system of care in which people get the help they need as early as possible, in the safest and least-restrictive setting as possible. This is underscored in The National Association of State Mental Health Program Directors' (NASMHPD) recent report entitled, *"Beyond Beds: The Vital Role of a Continuum of Psychiatric Care."* [19, 20] Other initiatives such as *Crisis Now* describe systemic approaches to community-based crisis services that are often less costly than more restrictive alternatives.[21]

This policy paper is intended as a guide for those who seek better ways to respond to individuals experiencing a BH crisis, beginning with the moment a request for help is made and ending with the successful transition to an appropriate level of care. We describe best practices for LE crisis response and outline the components of a comprehensive continuum of crisis care that provides alternatives to LE involvement, ED utilization, and hospital admission. We discuss the importance of addressing this complex issue from a systems approach rather than relying on standalone programs for an easy fix. Finally, we present policy considerations to assist communities to take concrete steps towards building an advanced crisis response system.

Law Enforcement Responses

The LE response to BH crisis has been under increasing scrutiny by the courts for several decades. In particular, the 9th Circuit Court of Appeals 2011 ruling in Glenn vs. Washington was a critical decision in the movement to improve outcomes for individuals experiencing behavioral emergencies. In this case, which involved the death of a young man in crisis holding a knife, the Court upheld an earlier ruling (Deorle v Rutherford, 2001)[22] stating that "we have made it clear that the desire to quickly resolve a potentially dangerous situation is not the type of governmental interest…that justifies the use of force that may cause serious injury." Furthermore, they underscored that the use of less forceful tactics is expected when responding to calls involving a person in emotional distress who is causing a disturbance or resisting arrest. Instead, LE officers should be expected to proceed slowly and figure out how to de-escalate the situation. This decision became the basis for many LE agencies to implement or expand Crisis Intervention Team (CIT) programs.

CIT and Training

The CIT model is the most widely known approach to providing LE with the tools needed to recognize individuals experiencing a BH crisis, deescalate them, and divert them to treatment instead of jail. CIT began in the late 1980s in Memphis, Tennessee, in response to a police shooting involving a person with mental illness. The centerpiece of CIT is a 40-hour training that involves scenario-based exercises and participation of community stakeholders including BH clinicians, treatment agencies, people with lived experience of mental illness, families, and advocacy groups.

CIT training is associated with higher likelihood of referral to treatment and lower likelihood of arrest, and CIT trained officers are more likely to use verbal redirection as the highest intensity level of force in the field.[23] CIT training is most effective when undertaken voluntarily by experienced officers. Compared to officers mandated to receive CIT training, voluntarily trained officers demonstrate better self-efficacy, de-escalation skills, and referral

decisions. Even when physical force was documented, voluntarily trained CIT officers were more likely to refer to treatment services and less likely to make an arrest.[24] It is estimated that 3,000 jurisdictions across 47 states have implemented CIT programs.[25]

The National Council for Behavioral Health and CIT International recommend that 100% of a department's uniformed patrol officers receive a required 8-hour Mental Health First Aid for Public Safety training while 20-25% voluntarily receive the 40-hour CIT training. 9-1-1 personnel should also receive training to help them recognize calls with a mental health nexus so that they can dispatch CIT trained officers when needed. This approach ensures both a basic level of competency among all officers and 24/7 availability of a specialized CIT response.

While CIT is often thought of as a police training program, its creators continue to underscore that training is only one part of a more comprehensive community approach.[26] Once officers are trained to identify a person in crisis and divert them to treatment, their first question is often "divert to what?" For this reason, the full CIT model recommends a crisis system that is ready to receive individuals from LE with quick and easy access and 24/7 availability. In practice, services are often not available and patients instead board in EDs waiting for inpatient beds. Oftentimes the officer must wait with them, sometimes for hours, making jail the path of least resistance for busy officers juggling multiple calls for service.

Beyond CIT: Dedicated Specialty Teams

Some LE agencies have created BH specialty teams composed of dedicated—not designated—personnel. This is a crucial distinction in LE. CIT trained officers are often *designated* to handle BH calls in addition to their regular duties, whereas *dedicated* teams focus exclusively on BH concerns. Team members may respond to mental health calls like regular CIT officers, but their specialization provides time and flexibility to problem-solve complex cases and collaborate with mental health partners on system improvement efforts. Examples include substance use teams that connect people to treatment in lieu of arrest, mental health case management teams that follow up with individuals after a crisis, investigative teams that seek to connect individuals to treatment before they reach the point of crisis, and homeless outreach teams. This level of resource commitment indicated leadership buy-in, and many of the agencies recognized as Police-Mental Health Collaboration Learning Sites (described below) have some form of dedicated team, in addition to CIT training, as part of their comprehensive approach to BH.

BH Crisis Response

Currently there are no national standards for crisis services like that of Emergency Medical Services (EMS) systems. However, several emerging frameworks have started to define crisis services and how they should interact with LE:

> *The Sequential Intercept Model* describes the typical pathway through criminal justice system for a person with BH needs and identifies opportunities for the healthcare system to intervene.[27] Intercept 0 (community-based crisis services) and Intercept 1 (9-1-1 and first responders) describe opportunities for crisis and LE to collaborate to prevent LE contact or arrest.[28]

Crisis Now: Transforming Services is Within Our Reach, is a 2016 report that lays out essential services for a crisis continuum of care: call centers, mobile crisis teams, and stabilization centers.[29]

National Guidelines for Crisis Care: A Best Practice Toolkit was released in 2020 by the Substance Use and Mental Health Services Administration (SAMHSA) as an update to Crisis Now.[30]

21st Century Behavioral Health Crisis Care is a report by the Group for the Advancement of Psychiatry, in collaboration with the National Council for Behavioral Health, scheduled to be released in 2021 that describes the services, competencies, and governance needed to create a coordinated crisis system with measurable outcomes.[31]

Crisis Call Centers and "Care Traffic Control"

Crisis call centers are often the first entry point to crisis services and, in some instances, can take the place of 9-1-1 calls that might otherwise have resulted in police dispatch. Crisis lines offer support to people in crisis 24 hours a day, 7 days a week via a range of modalities such as suicide hotlines, warm lines, and text functions. The National Suicide Prevention Lifeline (NSPL), launched in 2005, is a network of more than 170 crisis call centers located in communities across the U.S. that are supported by SAMHSA and local funding. The Veterans Administration Crisis Line (VCL) is linked to the NSPL, has since its inception in 2007 responded to more than 3.9 million calls, 467,000 online chats, and 123,000 texts.[32] In some communities crisis calls are accessed through nonemergency and information lines such as 2-1-1 and 3-1-1 or other local crisis lines. Studies of NSPL call centers have found that callers have significantly decreased suicidality during the course of the call,[33] a third are successfully connected with mental health referrals,[34] and less than a quarter result in LE or EMS being sent without the caller's collaboration.[35] As awareness of the utility of crisis lines increases, there has been growing momentum to create a nationwide, easy to remember three-digit number for NPSL and other crisis lines. The Federal Communications Commission (FCC) recently approved a new 9-8-8 number for implementation in July 2022.[36]

In addition to crisis counseling, crisis call centers are well situated to serve as a centralized hub for relaying information and coordinating the appropriate response. Such "care traffic control" functions include dispatching the nearest mobile crisis team, making outpatient appointments, and finding placement in crisis facilities or inpatient units. Some systems even have clinicians embedded in 9-1-1 communications centers so that BH calls can be diverted to the crisis line in lieu of a police response. Local and regional mental health system leaders must engage with relevant emergency management agencies to develop clear protocols and clinical criteria for when to dispatch a clinical team, LE, or both. Such policies and procedures can also help reduce the potential for implicit bias to affect decision-making.

Mobile Crisis Teams

Mobile crisis teams (MCTs) play a critical role in providing access to care for people in crisis. The first MCTs are believed to have been established as early as the 1930s in Amsterdam.[37] As of June 2020, at least 34 states in the U.S. have MCTs, although few operate statewide.[38] MCTs are typically composed of one or two providers including masters-level clinicians and psychiatric technicians[39] and frequently interact with EMS, LE, and CIT-trained officers.[40, 41] MCTs meet the patient where they are—at home, in the ED, on the street—obviating the need to transport them to a more restrictive environment.[42, 43, 44] MCTs should have

clear clinical criteria for when to request assistance from LE. Standardized protocols reduce the potential for implicit bias to affect clinical decision-making that may unnecessarily expose people of color to higher rates of LE involvement.

Some localities have established centralized dispatch for MCTs, often within crisis call centers. To improve response times, MCTs may be stationed throughout larger geographical areas (e.g., in police departments or outpatient clinics). Rural areas in particular benefit from dispersed models that are centrally coordinated. A more advanced approach is illustrated by the crisis line in Tucson, Arizona, which uses mobile phone software with GPS technology. Dispatchers can see each MCTs' location and status, allowing them to identify teams that are nearby or close to finishing up an encounter, similar to popular app-based ride hailing companies. The app also facilitates transmission of clinical information from the crisis line dispatcher to the MCT to assist with continuity of care.

Co-Responder Teams

In co-responder models, a BH clinician co-responds to crisis calls with LE. This model is popular in the United Kingdom and Canada (where it is sometimes called "street triage") and was pioneered in the U.S. by the Los Angeles Police Department in the early 1990s. There is wide variability in how co-responder programs are operationalized.[45] Models include teams that ride and respond together, teams that arrive separately, and teams where only the officer responds to the scene with clinician support via phone or video. Some programs have plainclothes officers in unmarked cars, while others are uniformed. There is no consensus on which model is most effective, and programs should be adapted to the local context. For example, an officer and clinician riding together may work well in a dense urban area with a high volume of mental health calls, while a more sparsely populated area may be better served by one of the other models. EMS co-response models have also been implemented. Developed in 1989 in Eugene, Oregon, the CAHOOTS (Crisis Assistance Helping Out On The Streets) program pairs a clinician with EMS to respond to crisis calls.[46] The RIGHT (Rapid Integrated Group Healthcare Team) Care model, operating in Dallas, Texas, deploys a three-member team of a clinician, LE officer, and paramedic.[47]

While community members report they prefer the co-responder model to a police-only response, studies of other outcomes have been mixed.[48] A review of police and mental health co-responder programs concluded that these programs decreased arrests and the amount of time officers spent handling mental health calls, but there was limited evidence on other impacts.[49] Furthermore, many programs are limited in scope in terms of hours or operation or geographical area served. In particular, programs experience difficulty when there is a lack of community mental health resources. While co-responder models have recently received much attention, they are not a panacea but rather one component of a larger crisis response system.

Specialized Crisis Facilities

Crisis facilities vary widely in scope and capability. Some are designed for low acuity patients who primarily need peer support and a safe place to spend the night, while others treat the highest acuity patients presenting as danger to self or others, acute agitation, and substance intoxication. When coupled with the lack of standardized nomenclature, this variation can create confusion for community stakeholders and policymakers unless expectations are clearly articulated and understood.

From its inception, the CIT model outlined requirements for a "receiving center" where officers can bring individuals for treatment.[50] These include 24/7 availability, faster drop-off times than jail, and a policy of never turning officers away. Ideally, the center should be able to accept any patient regardless of behavioral acuity, including those who may be suicidal, violent, or intoxicated. Such a "no wrong door" policy ensures that highest acuity patients receive care in a specialized setting designed to meet their needs.

Receiving centers are known by a variety of names— crisis stabilization units, 23-hour observation units, psychiatric emergency services units, emPATH (emergency Psychiatric Assessment, Treatment & Healing) units—and may be free-standing or adjacent to a hospital or ED. Many also receive patients via LE, MCTs, transfers from EDs, and walk-ins.[51] Crisis facilities provide a safe and therapeutic environment for assessment and stabilization, with interdisciplinary treatment teams that include psychiatric providers, social services staff, nurses, BH technicians, or peer supports. With rapid assessment, early intervention, and proactive discharge planning, most patients are able to return to community-based care. Studies show these units are associated with reduced rates of hospitalization, boarding of psychiatric patients in EDs and arrests.[52, 53, 54]

Living Rooms, detoxification centers, and sobering centers provide 24/7 alternatives for less acute needs and often accept police drop-offs for patients who meet their admission criteria. They are typically unlocked and serve patients who are voluntary, non-violent, and motivated for help.[55] Living Rooms offer a home-like environment with couches and artwork and are staffed predominantly by peer specialists, with limited coverage by a psychiatrist or other provider. They are especially helpful if psychosocial stressors are the main precipitants of the crisis. Detoxification centers provide medically supervised detoxification services, while sobering centers employ primarily psychosocial and peer support.

Crisis clinics or mental health urgent care centers offer same-day or walk-in access for outpatient assessment, crisis counseling, medication management, and coordination of care, including enrollment in benefits. These clinics can be part of a crisis center, ED, outpatient specialty mental health clinic, or standalone, and provide bridge services until the person is connected to appropriate outpatient care.

Crisis residential, crisis respite, and peer respite facilities offer longer term (days to weeks) residential care. They are often used as step-down from inpatient care. Some programs may accept low acuity patients from LE.

Post-Crisis Care

Post-crisis wraparound services are increasingly recognized as essential to ensure that patients are successfully linked to long-term treatment and avoid reutilization of crisis and other acute services.[56, 57, 58] These services can be provided by BH programs (e.g., peer navigators), LE-based case management, or a combination of both. In addition, community paramedicine approaches deploy paramedics to check on frequent 9-1-1 callers, some of whom have BH needs.[59] In each model, the goal is for crisis services to connect people to treatment and address the social determinants of health (e.g., housing, transportation, food) with the goal of preventing future encounters with LE.

Advanced Systems

Crisis Services vs. Crisis Systems

While each of the various programs described thus far is likely to improve outcomes in isolation, the impact is multiplied when an array of programs and services work together as a coordinated system to achieve common goals. This approach is illustrated in Figure 1, which is based on the crisis system in Tucson, Arizona. In this model system, healthcare and LE stakeholders agree on a common goal of preventing avoidable jail, ED, and hospital use by providing care in the least restrictive setting that can safely meet the needs of an individual experiencing a BH crisis. Because less restrictive settings tend to be less costly, clinical and financial goals are aligned. In Arizona, a Regional Behavioral Health Authority (RBHA) contracts with multiple BH agencies to create an array of services organized along a continuum of intensity, restrictiveness, and cost. At all points along the continuum, which in this case includes co-location of crisis call center staff within 9-1-1, co-responder teams, and crisis facilities, easily accessible handoffs by LE facilitates connection to treatment instead of arrest. To further incentivize coordination, some contracts confer a "preferred customer" status to LE, so that, for example, response time targets for MCTs are faster for calls that involve LE.

Governance and accountability are key to ensuring that crisis services operate as an organized and coordinated system. In the Arizona model, the RBHA serves this function via its role as the single payer and regulator for the crisis system. Other systems may be governed by counties, cities, or formalized stakeholder groups. Regardless of the convener, advanced crisis systems should have governance and accountability structures that align the various services towards common goals, foster collaboration between a broad array of community stakeholders (e.g., LE, health systems, schools, etc.), operate with a "no wrong door" approach where components collaborate to deliver services without restrictive entry or exclusion criteria, and use data to measure outcomes, make decisions, and improve performance.

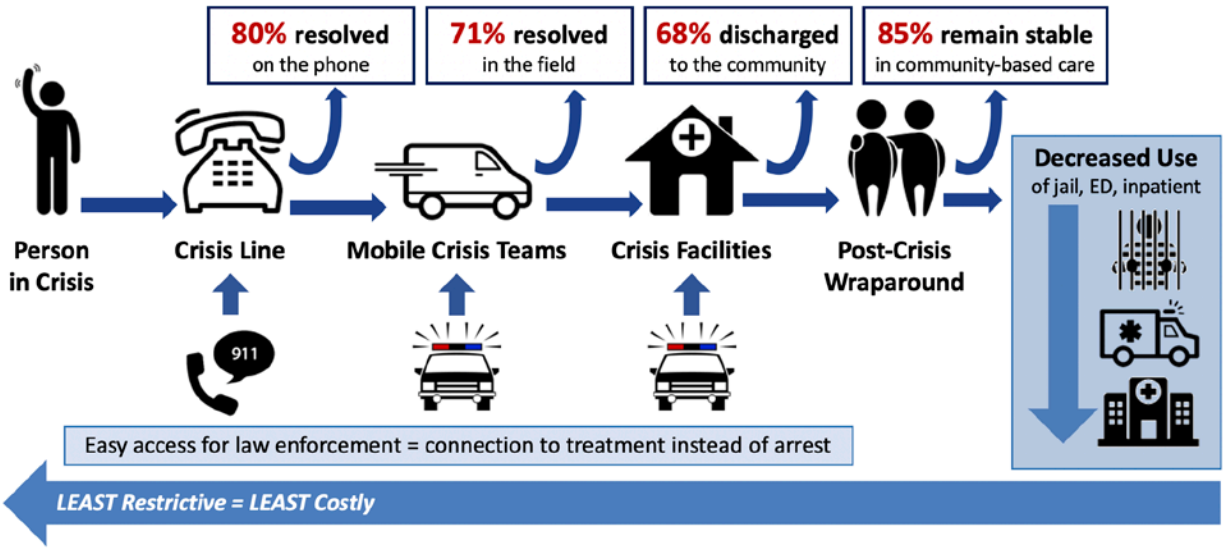

Figure 1. Alignment of crisis services towards a common goal. In a high functioning system, the individual services in the continuum work together to achieve a common goal, in this case, stabilization in

the least restrictive (which is also the least costly) level of care. Data is provided by Arizona Complete Health and applies to the southern Arizona geographical service area for FY2019. Crisis line resolved calls is the percentage of calls resolved without dispatching CMT, LE, or EMS. MCT resolved cases is the percentage of face-to-face encounters resolved without the need for transport to a higher level of care. Crisis facilities community disposition is the percentage of discharges to levels of care other than hospital, ED, or jail. Continued stabilization is the percentage of individuals with an MCT or crisis facility encounter who did not have a subsequent ED visit or hospitalization within 45 days.

"One Mind" Law Enforcement Organizations

Social movements such as Black Lives Matter have motivated communities to examine the role of LE in supporting the safety and welfare of their citizens, and there is growing momentum for policing reforms such as community-oriented policing and procedural justice that seek to improve trust and legitimacy between LE and the communities they serve. The treatment of a community's most vulnerable members plays an important role in building that trust, and thus improved responses to BH crisis are critical to reform efforts.

Like crisis systems, public safety agencies benefit from a broad organizational approach that goes beyond the implementation of a single program or training. The International Association of Chiefs of Police (IACP) created its "One Mind" campaign to encourage this type of systems thinking, challenging LE leaders to begin by committing to three core elements: partnership with community mental health agencies, model policies to guide interactions with individuals experiencing a BH crisis, and training programs built on Mental Health First Aid and CIT.[60]

Figure 2 illustrates how these elements fit together to create a systematic approach across the Tucson Police Department. Leadership provides the foundation by creating the culture and operational procedures needed to support safe and compassionate interactions with people in crisis. Mental Health First Aid training provides a basic level of competency to all officers, while those with the aptitude and interest are encouraged and incentivized to pursue more advanced CIT training. Specialized teams receive further training such as Motivational Interviewing and Trauma-Informed Care and work to develop partnerships with BH agencies and other community partners As they continue to gain knowledge and experience, these specialized teams also serve as subject matter experts to the rest of the organization.

A growing number of LE agencies have developed similarly sophisticated strategies for addressing BH emergencies. The U.S. Department of Justice Bureau of Justice Assistance has identified ten such agencies departments as model programs called Police-Mental Health Collaboration Learning Sites. These agencies serve a wide range of jurisdictions in terms of population size and geographical distribution. Most employ a number of the programs described in this paper, tailored to work for their individual communities. What makes these departments exceptional is that these programs fit within comprehensive, agency-wide approaches in partnership with BH and other social service agencies. Details about each program can be found on the Learning Sites website,[61] and funding is available for site visits and other technical assistance. In addition, the Council of State Governments, which supports the Learning Sites program, has created an online *Police-Mental Health Collaboration Toolkit* to help LE executives to develop or advance approaches to addressing BH crisis.[62]

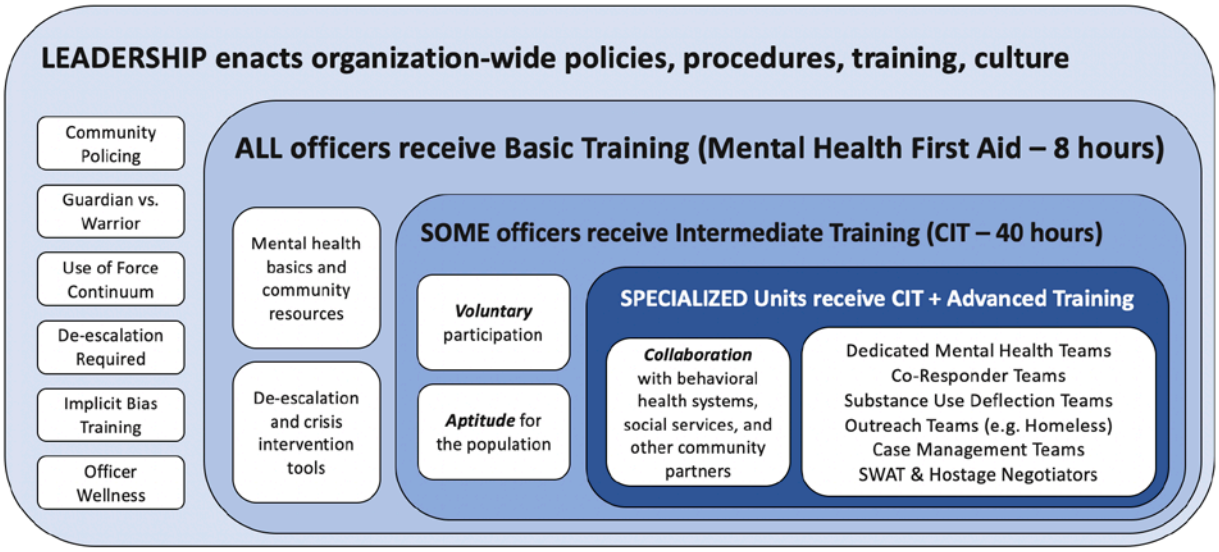

Figure 2: Organizational approach to serving community members with BH needs.

Cost Savings Across Systems

Numerous studies have demonstrated that crisis services reduce spending on ED visits and inpatient hospitalizations. For example, in one study, a mobile crisis intervention decreased spending on inpatient admissions by 79%,[63] and in another, the addition of a clinician co-responder reduced costs by 23% compared to regular policing due to fewer inpatient admissions.[64] A claims analysis of crisis stabilization services estimated a $2.16 return on investment due to savings in inpatient, outpatient, and ED utilization.[65] The Health Care Financial Management Association estimates that eliminating unnecessary ED use for BH emergencies in the U.S. could save as much as $4.6 billion annually.[66]

Better crisis response benefit LE and the justice system as well. CIT training in the Denver Police Department resulted in follow-up care for more than 44% of individuals rather than arrest and incarcerations, saving the state more than $3 million in jail expenses.[67] By changing the response to suicidal patients "barricaded" in their homes, the Tucson Police Department reduced the number of SWAT deployments from 14 per year to 2, at a cost savings of $15,000 each.[68]

The true power of a collaborative approach is illustrated by studies of savings across healthcare and justice systems. Maricopa County, Arizona, has a robust crisis system composed of call centers, mobile teams, and crisis stabilization centers. In 2016, the system served approximately 22,000 individuals and generating savings of $260 million in hospital spending, $37 million in ED spending, 45 years of ED psychiatric boarding hours, and 37 full-time equivalents (FTEs) of police officer time and salary.[69]

IV. Policy Implications

To create high-functioning systems, a range of policies across multiple stakeholders must be put in place.

Civil Commitment and Mental Health Transports

While many people in crisis voluntarily seek care, there remains a subset who lack the capacity to make rational decisions. In these situations, state civil commitment statutes define the role of LE in detaining and transporting individuals involuntarily for psychiatric evaluation.[70] In some states, only LE— not clinicians or family—can initiate the process to petition the court for emergency psychiatric evaluation. Even if civilians can initiate petitions, some states require that the individual's risk of harm to self or other be "imminent." Waiting for the situation to decompensate to the point of present dangerousness creates the conditions for a volatile and risky encounter with LE. Furthermore, existing laws often dictate that involuntary transports to crisis or other treatment facilities must be performed by LE. However, a recent survey of LE agencies estimated that 65% of transports did not pose a risk of harm to others and could be completed by another entity.[71] Many of these laws were written decades ago and should be updated to include earlier interventions and alternative crisis responses rather than relying so heavily on LE. LE should provide transport only when no other means is available to protect the safety of the individual or those providing the transport. The use of handcuffs or physical restraints should be a last resort and limited to those persons who have been identified as risks to themselves or others without the use of restraints.

Regulations and Accreditation Standards

Because most crisis services are funded and regulated at the state or local level, there is wide regional variation in terms of program definitions, licensure, accessibility, and quality. National standards are needed in order to ensure consistent quality across crisis services and systems. The upcoming *21st Century BH Crisis Care* report, created in response to the federal Interdepartmental Serious Mental Illness Coordinating Committee's call for national standards, will be the first attempt at defining measurable standards for a comprehensive crisis system, inclusive of service continuum, governance/finance, and clinical quality.[72] In the meantime, accreditation exists and should be incentivized for some individual crisis programs via organizations such as the American Academy of Suicidology, CARF International, and the Joint Commission.

Standardized practice across the nearly 18,000 LE agencies has been even more challenging. While best practice standards have been proposed through initiatives such as President Obama's 21st Century Policing Task Force[73] and IACP's One Mind Campaign, participation is voluntary. Too often, reform and accountability are only realized after a Department of Justice consent decree is enacted. However, there is growing support for policing reform legislation that include accreditation standards and incentives for LE agencies to adopt more progressive practices.

Financing

With organized governance and financing structures, communities can braid funding streams from federal, state, and local sources to create robust crisis systems that provide both good care and responsible stewardship of public funds. Medicaid in particular is a critical

component of crisis financing, and thus Medicaid expansion is one straightforward strategy for states to enhance crisis funding. All states use Medicaid to finance some degree of crisis services (e.g., reimbursement for billing code "H2011 – Crisis Intervention Service"), but those with managed Medicaid have increased flexibility to fund a wider variety of crisis services via 1115, 1915(b), or 1915(c) waivers. Managed care organizations provide a structure to combine multiple funding streams such as state and local funds earmarked for crisis or indigent care, SAMHSA Mental Health and Substance Abuse Block Grants (MHBG and SABG), and other federal grants such as Projects for Assistance in Transition from Homelessness (PATH) grants and Cross Area Service Program (CASP) grants. Such arrangements maximize efficiency and accessibility by pooling resources to create a common safety-net crisis infrastructure that can serve anyone in need, regardless of payer.[74] Emerging financing models such as value based payments provide additional mechanisms for Medicaid programs to invest in crisis and other social services, and future federal budgets may include a crisis "set aside" in the MHBG.[75, 76]

In contrast, Medicare and most private health plans provide little or no coverage for crisis services. When privately insured individuals receive crisis care, the cost is either uncompensated or borne by public safety-net funds. These payers must be held accountable to provide parity coverage for BH emergency care. The Centers for Medicare and Medicaid Services (CMS) Emergency Triage, Treat, and Transport (ET3) demonstration program provides parity Medicare reimbursement for EMS to transport to "alternative" destinations other than the ED, including crisis facilities.[77] Models like this are a step in the right direction

In communities with robust crisis systems, co-responder and other support personnel can be allocated to collaborate with and assist LE officers without additional cost to LE agencies. There are also federal grants such as the COPS (Community Oriented Policing Services) and Byrne Memorial Justice Assistance Grants that LE may use to create BH programs.

Policy makers, state officials, and payers may express concerns about the costs associated with funding a crisis system. The cost savings described above must be presented in a compelling narrative to convince decision-makers that the costs of *not* doing so is neither good business sense nor good for community health and safety.

Data Sharing and Quality Improvement

Individual-level data sharing can help LE agencies and BH providers coordinate care for individuals involved in both systems. For example, knowing that someone is receiving BH services can help LE officers choose the most appropriate intervention when coming into contact with that individual. Conversely, LE officers often have information about past interactions and psychosocial factors that can aid clinicians in their assessment. When developing data sharing protocols, it is important to reach consensus regarding relevant state and federal laws and to include input from stakeholders with lived experience. The Health Insurance Portability and Accountability Act (HIPPA) is often seen as a barrier but does allow data sharing in emergencies. Data can also be shared via Business Associate Agreements (BAA) or by obtaining consent from the patient.

Data is a powerful tool for quality improvement across the entire system,[78] and performance data will also be increasingly tied to financing as alternative payment models evolve. Data can also be used to improve health equity by deliberately looking at disparities in outcomes among underserved populations. However, very few quality measurement standards exist for BH crisis services. Some standard measures are in use by crisis call centers[79] and a measure set for crisis facilities has been proposed.[80] Reporting through SAMHSA's Uniform

Reporting System, which is already required of states receiving MHBG funds, may be expanded to include crisis metrics if the MHBG crisis services set aside is approved in upcoming federal budgets.[81]

For now, communities will continue to be compelled to define metrics that reflect their values. Aligning metrics across multiple system components can guide the system towards common goals. For example, in Figure 1, the various system components—call center, mobile teams, crisis facilities—report the percentage of patients stabilized without the need for a higher level of care. Each of these measures is one facet of the overarching goal of crisis stabilization in the least restrictive setting possible, and can be organized into a dashboard that monitors performance relative to that goal. System partners can then use real-time outcomes to identify targets for improvement and organize improvement initiatives.

For communities just beginning to organize, data collection can be a good first step. Data helps to engage stakeholders and build the business case for investing in crisis services. Furthermore, data sharing with the public and key community stakeholders can garner trust and legitimacy for LE agencies attempting to improve their approach to BH emergencies.

Stakeholder Engagement and Collaboration

Strong partnerships are critical to generating the enthusiasm to design, fund, and implement crisis systems and ensure they function effectively on an ongoing basis. Potential stakeholders include state and local governmental agencies, payers, LE agencies, emergency management agencies responsible for 9-1-1 dispatch, BH providers, social service agencies, and consumer advocacy groups representing people with lived experience of a BH crisis. Strategic inclusion of elected officials or other influential community leaders can be an effective way to garner support.

How to begin largely depends on the dynamics of each local community. Momentum may come from a variety of stakeholders, including counties seeking to reduce their jail population, EDs overcrowded with psychiatric patients, LE agencies strained by mental health transports, or community leaders galvanized by a tragic outcome involving a person in BH crisis. Collaborative groups can be built upon existing organizational infrastructure (e.g., a county task force) or created *de novo* as an independent group. Most localities already have at least some component of a crisis system in place, and system mapping exercises such as Sequential Intercept Mapping serve as a process to both ensure understanding of the existing context and engage additional stakeholders. Successful collaborations are iterative and longitudinal and may begin with small, simple improvements that require no additional resources (e.g., setting up a process for LE and BH agencies to communicate with one another in certain situations). By building on the success of these "easy wins," partners can progress to more sophisticated solutions. Eventually, the collaborative is no longer building a crisis system but rather monitoring and improving the system they built.

Disparities, Inequity, and Explicit Bias

Solutions will need to take into account the many complexities at play and explicitly address any forces that perpetuate stigma, health inequities, and racism, including how they impact crisis response decisions, service structures, and service delivery. Whenever possible, minorities, people of color, and individuals with lived experience should be involved in system planning to provide their perspectives on what it means to be a truly recovery-oriented, trauma-informed, and culturally responsive system.

V. Conclusion

As communities grapple with BH emergencies, the question isn't *whether* LE should respond to BH emergencies, but rather *when*, *how*, and *with what support*. Both LE agencies and healthcare systems must adopt systems approaches to serving individuals in crisis that strive towards a common goal of connecting people to care in the least restrictive setting, minimizing LE involvement when possible, while ensuring the safety of the individual in crisis, care providers, and the public. Stakeholders will need to collaborate closely to ensure adequate planning, financing, accountability, data collection, and oversight. Successful solutions have the potential to improve health outcomes for individuals in crisis, improve public safety by lessening demand on police, and reduce costs across the healthcare and criminal justice systems. With growing bipartisan support for meaningful change in these complex systems, every effort should be made to seize the moment and improve the accessibility, quality, and equity of BH crisis care in our communities.

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